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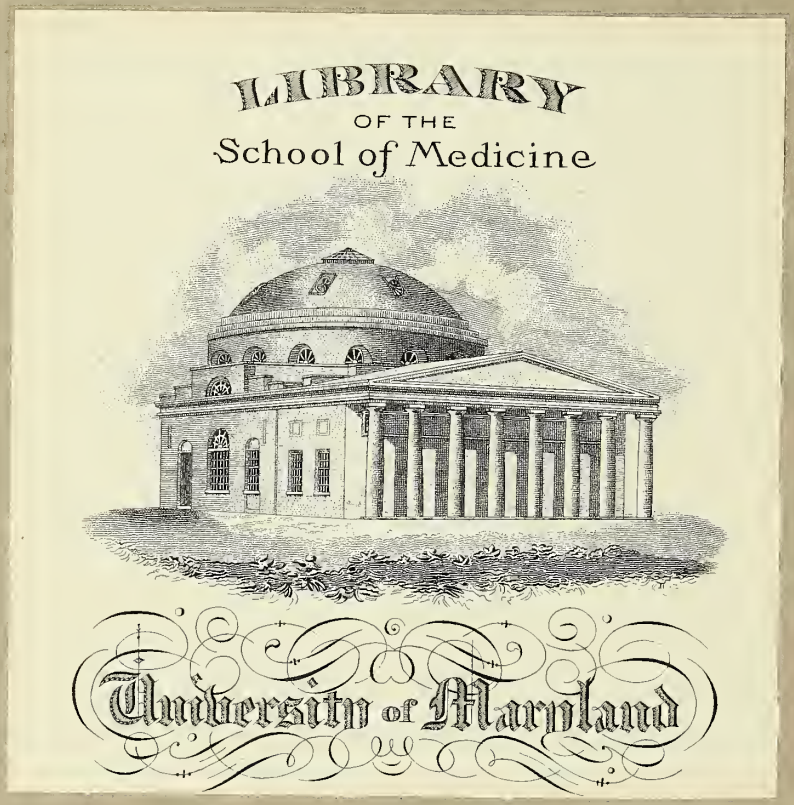

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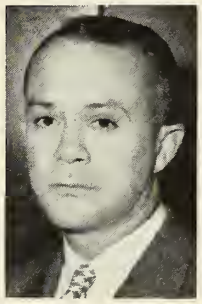
DYNAMIC THERAPY IN CHRONIC DISEASE*

DONALD A. COVALT, M.D.†

NEW YORK CITY

The Author:

Dr. Covalt is clinical director, New York University Institute of Rehabilitation and Physical Medicine; associate professor of Rehabilitation and Physical Medicine, New York University College of Medicine. He is a 1933 graduate of Indiana University School of Medicine, and was in private practice in Muncie from 1934 to 1942. He established the first AAF Convalescent Hospital, in Miami Beach, Florida, which served as a model for this and allied countries during the recent war.



THERE have been tremendous advances in medical and surgical care during the past fifty years, all of which have aided in the prevention of death. The end result of these advances has been an aging population in the United States.

For instance, United States census figures and reliable estimates for the future show that the proportion of the population over 45 years of age in 1900 was 17 percent; in 1940 it was 26½ percent; and it is estimated that by 1960 33⅓ percent, or one-third of our population, will be over 45 years of age. Even more dramatic is the percentage of the population over 60 years af age. In 1940, less than 7 percent of the population was over 60 years of age, but it is prognosticated that by 1980 over 15 percent of the population of the United States will be over 60 years old. In terms of the estimated population of 150 million people in 1980, this means that in 1980 there will be 21 million people of 65 years of age or older. These figures are startling proof that our population is shifting to the older age group.

Looking at it from another aspect, 2,000 years ago the average length of life was 25 years of age, and today the life expectancy is 65 years of age. We all know that as people become older their medical needs change and they require more medical service. In 1940 the 26½ percent of the nation's population over 45 years of age required one-half of the nation's medical services. By 1980 the number of persons over 45 years of age will constitute nearly one-half of the entire population.

The actual incidence of chronic disease in the United States is not known since reliable statistics are not available. As we all know, chronic disease, as such, is not reportable. We do know that in the National Health Survey it was found that over 23,000,000 people were in need of medical care for chronic diseases and in need of rehabilitation. Of these 23,000,000 persons who would benefit from further medical care, 2,500,000 were orthopedic cases, 7,000,000 were arthritic patients, 6,000,700 were cardiac patients, 750,000 were tuberculosis

* Presented September 29, 1949, at the Centennial Session of the Indiana State Medical Association, Indianapolis.

patients. These are in addition to the deaf and the blind. At New Haven, Connecticut, a recent survey conducted by the School of Public Health of Yale University found that on an average, 121 persons out of every 1,000 of the population suffered from chronic disease, and one-third of this group were totally disabled. *Even more astonishing* was the fact that one-third of this group was under 25 years of age.

A case in point is that of a patient, a man of 24 years, who was sent to the Institute of Rehabilitation from Alabama. This man had suffered a spinal cord injury by accident. A graft from the tibia was used to fuse the spine. An infection following the bone graft resulted in the loss of the left leg below the knee. When he arrived at the Institute he had an internal strabismus, was tongue-tied, had a paraparesis from the fractured spine, and a below-the-knee amputation of the left lower extremity. His tongue-tie was corrected surgically, the eyes were uncrossed, he was fitted with a prosthetic device and was taught to walk—all in the period of three months. Without adequate medical, surgical and rehabilitation care this patient would have continued to be a burden for many years on the state of Alabama. At the present time he is working as an orderly at the Institute eight hours a day and has not missed a day of work in the past eight months.

There is a great hue and cry now that there is not enough medical care. Can you imagine the great demand there will be in 1980 with the aging population? From an economical standpoint there will not be enough workers in 1980 to support the one-third to one-half of the population over 60 years of age. Nor does this group wish to be supported in convalescent and leisure time. Many men and women are at their greatest mental abilities at this age if they are only given a chance. Think what a loss it would have been to this country if our elderly statesman, Mr. Bernard Baruch, or the world-famous conductor, Mr. Arturo Toscanini, had been retired at the age of 60! The only answer to this problem is a complete and realistic medical and rehabilitation program for those people who need it.

There have been many examples as to how rehabilitation does pay off medically, socially, and economically. One instance is the Veterans Administration Hospital in Minneapolis. In a ward of 110 chronic neurological cases, all veterans of World War I, who had been in a hospital up to ten years, and many of whom had nurses around the clock and could not feed themselves—still at the end of nine months of intensive treatment, fifty-five of these patients were returned to their homes capable of self-care and able to do some kind of work; forty-five were progressing satisfactorily with their rehabilitation; and out of the entire 110 patients, only ten were not feasible for rehabilitation. With a five year life expectancy of the fifty-five patients who went home, and a per day hospitalization cost of over $12.00 daily, rehabilitation of this one group has saved the taxpayer over $1,250,000.

Another example of this need for total medical care are those patients with tuberculosis. In the United States 90,000 beds are used to care for tubercular patients at an expense of over $1,000,000 a year. One-half of these beds are filled with cases who have relapsed. It is a fact that one-half of all discharged tuberculosis cases will return to the hospital with relapse or die within five years. Still, in the state of New Jersey, with a real rehabilitation program, 511 cases were discharged in the past three years and only eleven have returned to the hospital, as against the 50 percent relapse rate throughout the country.

Rehabilitation has sometimes been called the third phase of medical care—the first being prevention, the second, diagnosis and treatment, and the third, what happens to the patient from the bed to the job. The practice of rehabilitation for any physician begins with the belief in the basic philosophy that the doctor's responsibility to his patient is not ended when the acute medical or surgical phase is over. Rather the doctor's job is not finished until that individual patient has been trained to work with what he has left. This basic concept can only be achieved if rehabilitation is an integral part of the medical service. Any rehabilitation program is only as sound as the basic medical service of which it is a part, for it is upon correct diagnosis and prognosis that the feasibility of training is determined.

The rehabilitation work-up must include, as well as the general diagnostic studies, muscle tests, range of motion, and tests for the inherent needs in daily living. A list of 102 items is used to determine the amount of the patient's self-care, and includes bed activities, such as moving from place to place in bed, and the ability to sit erect, toilet activities, eating and drinking activities, dressing and undressing activities, such as tying the tie, tying shoe laces, manipulating buttons, putting on and taking off braces. Also included are hand activities, such as turning knobs, pushing light switches, striking a match, and wheelchair activities, such as the ability to get in and out of the wheelchair and the control of the chair. For those patients who are able to ambulate, there are also the elevation activities such as going up ramps, getting up on a curb, and those activities necessary when a patient is traveling by car or bus.

This list of activities would appear to be a somewhat difficult project but in actual practice is easily carried out. Testing and checking can be done by a therapist or even a volunteer using a standardized test list. By using such a list, it is also possible to check the patient from time to time to see what progress he is making in his rehabilitation. Any of the self-care activities which the patient is not able to do are taught to him by a therapist so that the patient will be as completely

capable of caring for himself as is possible with his particular handicap at the time of his discharge from the Institute. To a patient who has been completely dependent, it is a great step forward when he is able to get from his bed to his wheelchair unassisted or when he is able to dress and feed himself unassisted.

Following the completion of the range of motion tests and the muscle tests and physical examination, the patient is presented to the entire staff of physiatrists, therapists, psychologists, and all consultants for evaluation and for the prescription of his rehabilitation program. Such a program is defined for each case according to his particular needs and may include physical modalities, corrective exercise, general conditioning, occupational therapy, psychological or even psychiatric studies, and vocational testing and counseling. The Institute places special emphasis on retraining in elevation, ambulation, crutch-walking, and the physical skills necessary for the activities inherent in daily living.

The facilities of the Institute are available to any patient who, in the opinion of the referring physicians and the staff at the Institute, would be benefited from rehabilitation and retraining. Patients are admitted either on an in-patient or outpatient basis. The majority of the cases referred require definite physical medicine or rehabilitation resulting from injuries, arthritis, orthopedic and neurological disabilities and diseases of the heart and arteries. Facilities are available particularly for paraplegics and hemiplegics.

The Institute does not provide vocational training as such; however, facilities are set up to do prevocational testing and special shops have been equipped for vocational evaluation and guidance for persons with all types of physical disabilities.

The specialized prosthetic service at the Institute is run on a consultative basis. The Institute does not manufacture or sell prosthetic devices but rather makes recommendations to the amputee as to the particular type of device best suited for him. The service also provides training lessons in the use of the prosthesis after it has been fitted and makes the minor adjustments whenever necessary. Skilled technicians are available for the adjustments and refittings so often necessary to make artificial limbs more comfortable and efficient to the wearer.

An excellent example of what this broader concept of medical care can accomplish is demonstrated in the patient with hemiplegia. We have had experience with some two hundred hemiplegias in the past two years and we find that approximately 90 percent of them can return to some kind of work with retraining. We have developed some very simple procedures for retraining the hemiplegic patient which can be carried on in the home by a therapist, nurse, or even a member of the family.

The physician who sees a hemiplegic patient the first time may utilize two simple tests to determine whether or not the patient will ever be able to walk again. First, is the patient able to move the arm on the affected side? We know that if he can move the arm on the affected side, he should be able to walk again, since the arm is always affected more severely than the leg. Secondly, is the patient able to move the leg on the affected side one inch off the sheet? Such a test indicates that he should have sufficient quadriceps power to learn to walk again.

The physician must also remember that certain types of hemiplegic patients are not feasible for rehabilitation measures. This group includes those with excessive hypertension or encephalomalocia.

There are three causes of hemiplegia: (1) Thrombosis, (2) Hemorrhage, and (3) Embolism. These are given in the order of frequency.

We start simple rehabilitation procedures on hemiplegic patients twenty-four hours after the return of consciousness where the cause of the hemiplegia has been thrombosis or embolism. Where the cause has been hemorrhage, the patient is kept on bed activities only for the first three weeks and then is permitted to sit on the side of the bed.

The following procedures should be instigated by the physician the first time he sees the hemiplegia to prevent the deformities that are so common in the hemiplegia, and these can be carried out easily in the home.

1. A pillow should be placed in the axilla on the affected side to prevent adduction deformity of the arm and shoulder.

2. A foot board should be placed at the bottom of the bed to prevent foot drop.

3. A sandbag should be placed along the outside of the affected leg to prevent outward rotation.

4. Pulley therapy for the shoulder on the affected side should be instituted early to prevent "freezing" of the shoulder and to re-establish reciprocal motion.

5. A "U" rope should be tied to either bedpost at the foot of the bed so that the patient may start sitting up in bed and learn balance.

6. Speech therapy should be instituted early and may be given by a speech pathologist or by a speech teacher from a local school.

7. The patient can learn very soon to sit on the edge of the bed, first with assistance and later by himself.

8. After he has regained some balance, the patient may stand by using the backs of two ordinary kitchen chairs to balance himself.

9. Later, the patient can learn to ambulate with a reciprocal motion by utilizing the backs of two kitchen chairs on a smooth surface. As he advances the left foot, the right chair is pushed forward

and when the right foot is advanced, the left chair is pushed forward, first with assistance and later alone.

10. We find that 50 percent of our hemiplegia cases need a foot brace of some type to prevent dragging the toe and to avoid inward rotation of the foot when walking.

11. Lastly, the patient must be taught the activities of daily living, such as how to tie his tie and shoe laces, and manipulate buttons—all of those simple activities which most of us do without thinking.

Many simple procedures can be carried out for the arthritic patient. We have adopted the rule of starting these patients on rehabilitation early, even if the sedimentation rate is elevated. We occasionally find that a high sedimentation rate drops when active rehabilitation measures are started. We give these patients activity to the degree that pain does not last more than one hour after the activity has been stopped. With an early rehabilitation program, we find there is less restriction of range of motion of joints, less stiffness, and less pain.

The patient with poliomyelitis can be started in his late convalescence with muscle re-education. Later, exercises are given to strengthen the affected muscles and to retrain the patient into utilizing those muscles he has left to carry out the activities of daily living.

At the Institute we have had over 250 cases of transection of the cord, either partial or complete. We have found that by using physical therapy and by retraining the muscles they have left, that many of these patients can be taught to ambulate, using braces and crutches. All of our paraplegias are taught to stand at least one hour a day to prevent the osteoporosis of the long bones which always occurs following months or years spent in bed.

I should like to stress that a full rehabilitation program is necessary for all of these patients and particularly for those patients with a severe orthopedic disability. We see many of these patients who have been getting heat and massage for months and even years with little improvement. It is essential rather that they have a full day's program directed toward their total needs. This program may include heat and massage, but also should include study of the psychological and social problems as well. These patients should spend five hours a day working toward their recovery. Under such a regimen, many of these patients can come back to self-care and the majority will be able to return to some kind of work again.

We know that rehabilitation centers and rehabilitation sections in university hospitals are not enough to solve the tremendous problem of rehabilitation for the aging population. Every physician must know about rehabilitation if this problem is to be solved. We believe that every physician is an essential and integral member of the team. The problems he is facing today with the over-sixty group will be magnified in the future and can only be met with knowledge of the field of rehabilitation. He, too, must be a teacher for his physically disabled patients—to teach them to "learn to live and work with what they have left."

John W. McPherrin, Editor of *The American Druggist*, upon his return from England, writes: "After five weeks in Great Britain, we came home with a new reverence for the faith of mankind that created America. It is our conclusion that there is no hope, peace of mind, or real security for anyone in the belief that 'THE STATE IS MY SHEPHERD, I SHALL NOT WANT.' This is the real concept of the Welfare State and it has done something to the British spirit. Nothing, not even a free health service, is more important to a nation than the spirit of its people."—*Illinois State Medical Society Secretary's News-Letter.*

THE SURGERY OF LARGE ARTERIES*

Louis G. Herrmann, M.D.

CINCINNATI, OHIO

Dr. Herrmann is associate professor of surgery, College of Medicine, University of Cincinnati; associate surgeon, Children's Hospital, University of Cincinnati; and attending surgeon, Cincinnati General Hospital. He received his A.B. from the University of Michigan in 1921; M.D. from Washington University in 1924; and visiting professor of surgery, University of Strasbourg, France, 1931. He is a diplomate of the American Board of Surgery.

IN THE field of vascular surgery many noteworthy advances have been made during the past decade, but those relative to the surgery of large arteries have been the most important and, perhaps, the most spectacular. The immediate seriousness of any wound of violence depends largely upon the extent and the kind of injury to the underlying large arteries. Surgeons have been interested in the control of hemorrhage from wounds of large arteries since the earliest times, largely because excessive loss of blood has always been a serious immediate consequence of any extensive injury. More recently, however, surgeons have become equally concerned about maintaining an adequate supply of arterial blood to the parts distal to the point of injury of a main artery so they might prevent the ischemic necrosis or gangrene which is another, equally serious complication of an extensive wound.

The surgery of large arteries, therefore, must be divided into two main groups. The first group includes those patients with injuries to large arteries. These patients should be of special interest to the general physician because he is frequently called upon to give emergency treatment to such injured persons. The second group includes those patients whose peripheral arterial circulation is altered because of some congenital anomaly of the great arteries or some disease of large peripheral arteries.

EMERGENCY MANAGEMENT OF ARTERIAL INJURIES

The immediate treatment of any injury which involves a large artery must be directed toward the prevention of excessive loss of blood. The application of a tourniquet above the site of an injury to control external bleeding must be discouraged since such a measure deprives the entire extremity of arterial blood and the resulting ischemia may produce irreparable damage to the limb. The use of hemostats to control bleeding from an injured artery should be avoided since they always produce permanent damage to the artery and make subsequent repair of the injured artery difficult. When hemorrhage is less severe and there is a possibility of preserving the viability of the extremity, the bleeding should be arrested by digital compression. Later the wound can be packed with gauze, with a reasonable amount of pressure applied through the bandage, until the bleeding is completely stopped. Hemostatic agents, such as gelatin sponges or fibrin foam, are valuable aids in controlling such external bleeding.

In addition to the direct attack upon the bleeding artery, there are other valuable and practical methods of diminishing the rate and amount of external or internal bleeding. Vertical elevation of the extremity with mild direct pressure in the wound will control bleeding from almost any peripheral artery until preparations can be made for permanent hemostasis. Supportive treatment should always be given before any definitive operation is undertaken. The proper use of transfusions of whole blood and plasma in adequate amounts is essential to successful vascular surgery. We consider it absolutely necessary to restore the volume of blood to approximately the normal level and to maintain adequate fluid and protein replacement in all patients who have lost large amounts of blood.

In many gunshot injuries of the limbs or neck, external hemorrhage may be slight or entirely absent even when one of the main arteries has been injured. This can be accounted for by the contraction of the artery and the curling of the intima with obstruction of the lumen when the artery is completely severed. Although subsequent thrombosis within the artery may produce occlusion of its lumen, we must not consider this as definitive treatment since secondary hemorrhage may occur

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after several weeks when such a thrombus becomes softened and is detached. Injuries resulting in incomplete severance of large arteries may give rise to profuse hemorrhage because the edges of the injured artery cannot retract and obstruct the lumen. In such patients a hematoma often forms in the soft part of the extremity and mounting pressure within it tends to restrict the flow of blood from the opening in the artery. However, if this blood infiltrates into the muscles of the extremity, serious compression of the collateral arterial pathways takes place with further impairment of the circulation distal to the point of injury. Reaction to this infiltrating blood causes edema of the muscles, and multiple incisions through the deep fascia of the extremity; may be necessary to decompress the muscles and prevent extensive gangrene of the soft tissues of the extremity.

In through-and-through bullet wounds of an extremity, when the external bleeding stops spontaneously and when no evidence of serious compression of the collateral arterial pathways is present, we do not believe that immediate surgical exploration of the artery is advisable. Early exploration of the wound, with its associated difficulties due to extravasated blood around the site of the injury, usually makes exposure of the injured artery difficult and the surgeon usually concludes the operation by ligating the injured artery and thus endangering the viability of that extremity.

When the bleeding from a large artery remains localized, it forms a pulsating hematoma which eventually develops into a **false aneurysm.** We believe that it is best to allow such a false aneurysm to become well established and to permit sufficient time for the extravasated blood to be absorbed. Definitive operation for the cure of the aneurysm, therefore, should be postponed until about three months after the injury. In some instances, however, secondary hemorrhage, dissecting hematomas, or infection may make it obligatory to carry out definitive treatment at an earlier time.

Arteriovenous aneurysms may cause early, acute cardiac decompensation and therefore may require definitive treatment without too much delay. Complicating lesions of nerves and bones rarely demand immediate surgical intervention and our experience has shown that the repair of these structures is also more likely to be successful if the operation is done as an elective procedure.

Much of the surgery upon large arteries, therefore, should be classified as elective surgery and the careful study and preparation of the patient is essential if the surgeon hopes to obtain lasting relief without serious complications from his operations. Successful arterial surgery depends upon adequate exposure of the injured arteries by properly placed incisions of reasonable length and careful dissection of the tissues with as little bleeding as possible.

PRINCIPLES GOVERNING SURGERY OF LARGE ARTERIES

Operative procedures which are designed to re-establish the continuity of large arteries must be performed soon after the initial injury if restoration of the arterial circulation is to be accomplished.

The successful repair of a wound of any large artery is a difficult task, and the surgeon must constantly bear in mind that blood vessels carry a remarkable fluid which normally has a tendency to congeal. The formation of clots of blood within large arteries after they have been repaired results in the failure to re-establish the functional activity of the artery. Most arteries which require repair are either diseased or damaged by trauma; consequently, the problems are different from those which concern the surgeon who plans to suture a normal artery of man or some experimental animal. In addition to the problem of intravascular thrombosis in the injured or repaired artery, the surgeon must concern himself with the adequacy of the arterial circulation beyond the point of injury to the artery. If our surgery is to be successful we must understand thoroughly the mechanisms which control the peripheral arterial circulation.

Collateral Arterial Circulation. The advantages of knowing the behavior of the peripheral circulation in the extremity or in the brain after the main nutrient artery has been severely injured should be obvious to all of us. It is our duty to ascertain by actual tests what alterations in the efficiency of the peripheral circulation will take place if the major arterial trunk to that part is permanently occluded during any surgical operation. When the collateral arterial circulation is active enough to keep the distal parts of the extremity in proper circulatory balance in spite of injury to or occlusion of the main artery, we believe it is inadvisable to spend the time and labor necessary to perform a successful repair of such an artery, since a single ligature on the proximal and distal ends of a completely severed artery will usually suffice to prevent further extravasation of blood into the muscles or to the outside. If temporary occlusion of the injured artery causes the extremity to remain cold and cadaveric in color, in spite of a satisfactory environmental temperature, it would be wise to postpone any surgical operation upon that artery. If, however, postponement of the operation is not possible because of the nature of the arterial injury, the surgeon must resort to every available means of restoring the continuity of the injured artery and of enhancing the collateral arterial circulation.

It is imperative to determine the patency of the communicating pathways between the vertebral arteries and the carotid arterial circulation before permanent obliteration of the internal or common carotid artery is undertaken. We advocate the use of local anesthesia when arteries of the neck are

to be exposed by operation, in order that the cerebral effects following temporary occlusion of the carotid arteries may be studied. If the patient shows no ill effects after fifteen to thirty minutes of temporary occlusion of the internal carotid artery, we can be certain that the collateral arterial circulation of the brain is adequate and permanent occlusion of that artery will be tolerated without complications. The fatal cerebral ischemia which occasionally follows the ligation of the common carotid artery is the result of pre-existing anatomic anomalies of the circle of Willis. We have followed the suggestion of Matas and have always applied an aluminum band when the common carotid artery was to be occluded, while the external carotid artery is always obliterated by a ligature. If the patient should show signs of cerebral ischemia within several hours after the operation, the aluminum band can be removed from the common carotid artery with complete restoration of the circulation.

Secondary Vasospasm. The sudden interruption of the flow of blood through a large artery of an extremity is usually attended by marked vasospasm in the entire vascular bed of that extremity; consequently, the degree of arterial insufficiency is often out of proportion to the local injury of the main artery. This secondary vasospasm must be relieved by reflex means, since the local application of heat to such an extremity is fraught with danger. Locally applied heat increases the local metabolism of the tissues but does not greatly enhance the flow of arterial blood to the distal parts of that extremity; consequently, the deficiency of oxygen to the tissues becomes greater and local death of tissue frequently ensues. In such instances, the use of vasodilating drugs, such as the oral administration of alcohol, the intravenous administration of papaverine or etamon, or the novocainization of the regional sympathetic ganglia should be carried out without delay. Occasionally after injury or repair of a large artery, the peripheral ischemia is so great that a sympathetic ganglionectomy or ramisection must be performed in order to bring about proper balance in the peripheral circulation.

OPERATIVE PROCEDURES UPON LARGE ARTERIES

Contrary to the general belief, there are still many dangers associated with the aseptic ligation of large arteries. Asepsis has greatly lessened the dangers of secondary hemorrhage and the secondary re-establishment of the lumen after ligation of a large peripheral artery; nevertheless, these dangers must still be kept in mind when large arteries of the trunk or neck are ligated or when the surgeon must deal with abnormally large and thin-walled peripheral arteries. Permanent occlusion will be more satisfactory if a wide segment of the artery is included in the ligature or the band, and also if the ligature or band is applied in such a way as to cause the least mechanical damage or fracture to the arterial wall. The process of necrosis of the artery will then take place slowly, and complete substitution of dense fibrous tissue for the necrotic tissue will ultimately take place.

Temporary Occlusion of Large Arteries. The method of temporarily occluding an artery by using a piece of cotton tape has the real advantage that no special kind of forceps is needed for the procedure. We use umbilical tape which is carefully passed around the artery and the ends held together in the hand. The slightly opened blades of a small artery clamp are placed on either side of the tape and, by a stripping movement, the loop of tape is completely drawn up to occlude the vessel. Twisting the tape to effect complete occlusion adds greatly to the risk of fracturing the walls of the artery and, therefore, such a maneuver must be employed with great caution. The use of an aluminum band, as suggested by Matas and Allen, permits complete occlusion of the artery without serious injury to the arterial wall.

Permanent Occlusion of Large Arteries. Permanent occlusion of large arteries can be accomplished by ligatures, cotton tape, metallic bands, strips of heavy fascia, or plugs of heavy fascia anchored within the lumen of the artery. It is necessary to remember that the portion of artery included in the ligature must undergo necrosis and the occlusion is made permanent by the substitution of living fibrous tissue for the necrotic tissue. For this reason, we do not advise the use of absorbable materials for permanent occlusion of large arteries because these materials may stretch or loosen and thus subject a necrotic portion of the artery to the pressure of the blood within the artery. It is important to use some unyielding material, such as silk, metal, or cotton tape.

The rate of necrosis of the arterial segment beneath the ligature varies directly with the size of the ligature and the size of the artery. A small ligature about a large vessel runs infinitely more risk of cutting through, with the result of secondary hemorrhage or restoration of the lumen of the artery, than does a large ligature or piece of cotton tape. We believe the ligature should vary in size directly with the size of the artery. When we are dealing with very large arteries, we believe that a transfixing suture of medium silk should be used to prevent the tape from untying or being blown off the end of the artery.

It is well known that the cutting effect of ligatures on large arteries is greatly reduced if the artery is divided instead of ligated in continuity. We therefore advocate the division of an artery which is to be permanently occluded by ligature, whenever it is possible. Occasions do arise when it is not advisable to divide the artery completely.

Aluminum bands may also be used for the per-

manent occlusion of arteries. These bands consist of strips of aluminum stock of 0.573 mm. thickness (23 Brown & Sharp's metal gauge) about $\frac{5}{16}$ inch wide, for the occlusion of an artery the size of the carotid artery. Strips of autogenous fascia have been used to occlude arteries and pieces of cellophane have been applied about arteries to cause gradual occlusion by fibrosis. Both of these methods have practical value.

The fundamental process of pressure necrosis by the ligature and the repair or replacement of this injured tissue is essentially the same in infected wounds as in clean wounds, except for the degree and rapidity with which these changes progress. The dangers of secondary hemorrhage are considerably greater after occlusion of a large artery in an infected wound. The infection hastens the dissolution of the segment of vessel beneath the ligature and frequently causes liquefaction of the blood clots and greatly retards the process of repair. We believe that this is more reason to use unyielding ligature material for the obliteration of large arteries in infected wounds.

When a major artery and its concomitant vein must be ligated, as would be necessary in performing an amputation of an extremity, it is important to ligate separately the main artery and the main vein. If the ligature includes both artery and vein, an abnormal communication between the artery and vein might result as the vessel walls beneath the ligature undergo the usual process of necrosis and replacement with fibrous tissue. The development of an abnormal arteriovenous communication in the amputation stump might eventually lead to serious complications.

After extensive injury to both artery and vein by gunshot wounds, stab wounds, or compound fractures, it is equally important that the proximal and distal ends of the injured artery and vein be isolated and ligated separately to prevent the subsequent development of an abnormal arteriovenous communication.

Suturing of Large Arteries. Since the successful repair of a wound of any large artery depends upon the prevention of secondary thrombosis at the site of suture, it is fortunate that we have available chemical substances which retard the intravascular clotting of blood. The most important of these substances is heparin. It is a natural anticoagulant which is normally present in the blood in small quantities. The prolongation of the clotting time of blood following the administration of heparin depends entirely upon the amount of the substance administered, and there is no phase when the clotting time cannot be altered by the injection of an active preparation of this substance. It is possible, therefore, to use heparin locally in the irrigating solutions at the site of the operation upon a large artery and it can also be given parenterally to reduce the clotting power of the blood in the entire blood circulation. Heparin in doses of 100 mg. to 150 mg., given intravenously every 4 hours, usually prolongs the clotting time of the circulating blood to about fifteen minutes. If the effect of heparin is to be neutralized at any time during or after a surgical operation, this can be done promptly by the intravenous injection of protamine sulphate.

If heparin is to be used following any surgical operation, careful attention should be paid to the hemostasis at the time of operation. It is wise to wait about four hours after the operation before therapeutic amounts of heparin are given. Careful observation of all patients receiving heparin therapy is essential and heparin should not be given to patients with known blood dyscrasias or obstructive jaundice. Heparin has proved to be a valuable adjuvant to the vascular surgeon. For prolonged reduction of the clotting power of the blood, we feel that dicumarol has many advantages over heparin, since it can be given orally once each day.

The most important cause of intravascular injury is the lodgment of a blood clot which has been carried distally from the heart, or from some larger peripheral artery, into an important secondary, peripheral artery. The sudden damage to the intima of the peripheral artery provokes marked reflex vasoconstriction in the entire vascular bed. The stagnation of blood brought about by the vasoconstriction favors progressive thrombosis within the vascular system of the entire extremity. Damage to the intima takes place easily and secondary thrombosis at this site begins within a few hours after the embolus has lodged. If there is evidence of progressive intra-arterial or intravenous thrombosis, it is imperative that we use anticoagulants to retard the clotting mechanism of the blood. The decision as to whether the acute arterial occlusion should be treated by conservative means, such as vasodilating drugs, optimum resting level, paralysis of sympathetic nerves, and passive vascular exercises, or whether surgical intervention should be resorted to without further delay is still a matter which requires keen judgment based upon wide experience. We believe that the conservative management should be given a fair trial of several hours before resorting to the less physiologic methods of arteriotomy and embolectomy. If the patient has been heparinized from the time the embolus lodged in the peripheral artery, it is safe to wait at least eight hours, and Murray believes it is possible to wait as long as twenty-four hours and still expect to relieve the obstruction by surgically removing the clot from within the artery.

We believe acute arterial occlusion should be considered as a surgical emergency and every means of promoting an adequate exchange of blood through the collateral arterial pathways should be instituted without delay. General conservative measures, in addition to early heparinization of the

patient, will usually result in satisfactory circulatory balance in the extremity; nevertheless, the surgeon must be ready to perform an arteriotomy and remove the embolus from the lumen of the artery if an adequate arterial circulation to the distal parts of the extremity cannot be brought about within six or eight hours by the conservative measures of treatment. A delay of twelve hours or more frequently deprives the surgeon of a chance to save the limb or even the life of the patient. It should also be borne in mind that the operation of embolectomy is an extremely delicate one and, if great care is not exercised in the removal of the intravascular clot, the added damage to the intima will result in subsequent thrombosis and occlusion of the artery. The site of lodgment of the embolus must be determined accurately and the artery exposed with as little surgical trauma as possible. The operation is best done under local anesthesia with adequate exposure by properly placed skin incisions. As soon as the artery has been freed of the embolus, it should be thoroughly irrigated with a 1:500 solution of heparin in normal saline solution. The intima and the media of the artery should then be closed by a running suture of very fine silk. When further clotting of the blood within the artery takes place, especially in older people, the problem becomes more difficult. If the thrombosis is not progressing actively into the smaller collateral pathways, there may still be some hope of saving the limb. Heparin should also be administered under these circumstances, but it must be remembered that it will not affect thrombosis which has already taken place. Resection of the thrombosed section of the artery has given satisfactory results in certain selected patients with thrombosis of the popliteal artery. This procedure, which is called arteriectomy, has a definite place in the management of arterial thrombosis in elderly people.

CONGENITAL LESIONS OF LARGE ARTERIES

The field of cardiovascular defects includes a wide variety of malformations. There are many complicated and rare types which are of academic interest only. The majority of these malformations are still not amenable to surgery, but the recent success in the surgical management of the more common varieties has opened an entirely new field of surgery.

Anomalous Arteries. The majority of anomalies of the aortic arch, exclusive of patent ductus arteriosus, give rise to few symptoms and have received little attention from a surgical point of view. Recently several of these abnormalities have been recognized as factors capable of producing troublesome and sometimes fatal compression of the trachea or esophagus. In 1945 Gross emphasized the importance of such anomalies and was the first to treat them successfully by surgical means. The conditions to which he has directed particular attention are: (1) right aortic arch in which the aorta passes behind the esophagus, with variable arrangements of the vessels arising from the arch which, often in conjunction with a patent ductus arteriosus or a ligamentum arteriosum, causes compression of the encircled trachea or esophagus; and (2) double aortic arch in which the ascending aorta splits into two limbs encompassing the trachea and esophagus and joining beyond to form the descending aorta. The posterior limb passes behind the esophagus and the anterior one in front of the trachea.

Whether symptoms develop as a result of such anomalies depends upon the size of the space between the encircling vessels in relation to the size of the encircled trachea or esophagus. The symptoms appear soon after birth, are referable to the compressed viscera and consist of dysphagia, wheezing respiration, stridor, retraction of the chest, and cough, all of which are increased during the act of swallowing. Frequent bouts of bronchitis or pneumonia result from aspiration into the bronchial tree of material spilled over during attempts to swallow. The diagnosis is readily made by roentgenologic means, whereby indentations can be seen in the esophagus after ingestion of barium sulfate and narrowing of the trachea is visualized after instillation of iodized oil.

The operation consists of relieving the constricting ring by dividing it at appropriate points. This may entail (1) division of the anterior limb of a double aorta at a safe site; (2) division of a patent ductus or ligamentum arteriosum; or (3) a combination of the two procedures. Gross obtained cures in two patients using these methods. These are the first and only surgically treated patients that have been reported. With the recent emphasis placed upon it, this condition should be more frequently recognized and more adequately treated.

Congenital Atresia of Large Arteries. Coarctation of the aorta is a congenital form of atresia characterized by fibrosed constriction in the aorta, just beyond the site of origin of the left subclavian artery. It may produce slight to complete obstruction of the aorta. The most important diagnostic sign is hypertension in the upper portion of the body, with hypotension in the lower portion, and with diminished or absent femoral pulses and signs of ischemia in the lower extremity. In rare cases, it has been found in other portions of the aorta but produces the same clinical signs and symptoms. The dangers of coarctation of the aorta are those incident to the hypertension that is produced and from the development of an aneurysm at the site of the constriction. This aneurysm may be of the dissecting type or may rupture directly into the pleural cavity. Streptococcus viridans endarteritis may be one of the complications which result from this congenital lesion of the aorta.

In October, 1944, Crafoord of Stockholm performed the first successful operation for the relief of coarctation of the aorta. He resected the oc-

cluded portion of the aorta between clamps and then performed end-to-end suture of the aorta. Gross recently reported forty-one patients with six deaths and thirty-two good results following this type of operation. Other observers have reported smaller groups of cases with equally good results.

Tetralogy of Fallot. The tetralogy of Fallot is present in the majority of cases of congenital cardiovascular defects which are accompanied with cyanosis. Prior to the brilliant contribution of Blalock and Taussig in 1943, patients suffering from this condition were faced with a hopeless outlook, only a few surviving beyond the first decade. The components of the tetralogy are pulmonic stenosis, interventricular septal defects, dextroposition of the aorta, and hypertrophy of the right ventricle. The chief disabling factor is pulmonic stenosis or atresia which prevents an adequate flow of blood to the lungs with resulting deficiency in oxygenation. It is in large part this factor which the Blalock operation attempts to overcome by anastomosis of one of the systemic arteries arising from the aortic arch to the right or left pulmonary artery.

The important diagnostic features in this condition are cyanosis, roentgenologic evidence of decreased size of the pulmonary artery, and absent or diminished pulsations together with absence of congestion in the lung fields. The most suitable age for operation is from two to ten years; it is not advised in infants eighteen months or younger.

Although each of the vessels arising from the aortic arch has been utilized for anastomosis, Blalock prefers the innominate and subclavian because of the better angle it makes when swung down to the pulmonary. The end of the systemic artery is best anastomosed to the side of the pulmonary artery, since in this way the new blood flow can reach both lungs, a condition which would not obtain in an end-to-end suture.

In general the results in the patients surviving operation have been phenomenal, and it has been remarkable how well the pathetic, weak, and cyanosed children have tolerated the operation. There has been little or no difficulty with the arm after sacrifice of the subclavian artery. It may be said that the operation represents an outstanding contribution to surgery, has proved thus far to be effective, and has given hope to hundreds of patients formerly doomed to death or early invalidism.

About a year and a half after Blalock and Taussig's first publication, Potts, Smith, and Gibson reported an ingenious operation for this condition, consisting of a side-to-side anastomosis between the aorta and the right or left pulmonary artery. This anastomosis was made possible by a specially devised clamp, which pinches off and occludes a portion of the aorta for suture but leaves a channel through which blood can continue to flow. The advantages of this operation are that the size of the artificially created communication can be varied to suit the needs of the patient, and it is well suited for use in patients in whom, because of the anatomy of the vessels, there is difficulty in making the systemic artery reach the pulmonary.

Beck's work in the re-establishment of coronary circulation by anastomosis of a systemic artery with the venous circulation of the heart is another step forward in this field of vascular surgery. He was the first to make a new branch of the aorta and successfully anastomose that artery to the coronary sinus of the heart, for the relief of myocardial ischemia. It is work of this type which will continue to push forward the frontiers of our knowledge of vascular and cardiac physiology.

The Cure of Aneurysms. The physical alterations of type and shape of an aneurysm must be kept in mind by the surgeon who plans the operative procedure for its cure. **Fusiform aneurysms** can rarely be treated successfully by plastic operations which are designed to restore the lumen of the artery. **Saccular aneurysms**, on the other hand, can often be cured by one of the restorative or reconstructive aneurysmorrhaphies of Matas; while cures may also be effected by complete excision with restoration of the lumen either by suturing or by transplanting a segment of vein to bridge the defect.

In every case of aneurysm in an extremity, the activity of the collateral arterial circulation must be tested before any operative intervention is attempted. If the collateral arterial circulation is inactive, we can be certain that the occlusion of the main arterial branch will result in serious arterial insufficiency and may even cause gangrene. There is usually no urgency about definitive treatment of an arterial aneurysm unless it shows signs of leaking. If it is advisable to stimulate the collateral arterial circulation in the limb, we usually resort to the simple method of repeated compression of the artery above the aneurysm for a period of days or weeks prior to definitive operation. If the establishment of an efficient collateral arterial circulation is more urgent, we resort to the use of passive vascular exercises.

Obliterative Endo-aneurysmorrhaphy without Arterioplasty. This operation is applicable to ordinary fusiform aneurysms. No attempt is made to reconstruct the parent artery and the arterial orifices are simply obliterated by sutures. By placing the sutures from within the aneurysmal sac, it is possible to obliterate the sac without disturbing the adjacent collateral branches and without interfering with the blood supply of the wall of the aneurysmal sac.

Extrasaccular Ligation without Arterioplasty. This operation has been performed most frequently in our clinic for the cure of fusiform aneurysms of the large arteries of the extremities. The extra-

saccular isolation of the incoming and outgoing artery after the aneurysm has been opened and the clots removed is simple. One does run the risk of interfering with important collateral arteries. Ligation of the incoming artery at a point where it is relatively normal is the surest way of preventing the recurrence of the arterial dilatation. We have not had serious ischemia result after this operation.

Endo-aneurysmorrhaphy with Complete Arterioplasty. In a fusiform aneurysm with a firm and resisting wall to the sac and one in which there are two openings near together on the floor of the sac, the operation can be performed with complete arterioplasty. This operation restores the lumen of the artery by making a new channel out of the wall of the aneurysmal sac. This is done by simply folding these edges over a small rubber catheter and then suturing the edges together with interrupted sutures. The center ones are kept loose until the catheter is withdrawn and then tied down to restore or make a new lumen for the main artery.

Matas emphasized that preservation of the arterial lumen is indicated only in the sacculated aneurysms with a simple opening where the parent artery already exists as a formed artery and in which the fistulous opening can be closed with great facility and simplicity. When the tests show the collateral arterial circulation to be good it is safe to ligate the incoming and outgoing artery of a fusiform aneurysm. In positions where many branches leave the main artery, as in the popliteal space, it is best to incise directly into the sac, remove the blood clots, and then identify the incoming and outgoing artery. These can then be ligated outside the aneurysmal sac or obliterated by sutures from within the sac. All branches must be identified and then ligated or obliterated by sutures. The sac can be allowed to fall back into the wound, and the wound can be closed over the sac.

Abnormal Arteriovenous Communications. When the ductus arteriosus does not close and remains open beyond the first year or two of life, the individual is left with a shunt which is essentially an arteriovenous fistula. After birth, the direction of blood flow in the ductus becomes reversed because the pressure within the aortic arch is now higher than that in the pulmonary artery; hence, blood now passes from the aortic arch into the pulmonary circuit. Such a communication may be tolerated extremely well if the individual is fortunate enough to escape any superimposed infection, and if the ductal shunt is a relatively small one. Under such circumstances, individuals have been found to have little or no incapacitation and have lived to advanced years. However, such a fortunate outcome is not in store for most individuals who possess a patent ductus arteriosus. There are certain hazards which are well recognized and which occur rather frequently: (1) The shunt may divert so much blood from the aorta that the peripheral circulation is deficient and the individual has a retarded physical development. While such subjects may be below par in weight and height, as a rule they have normal mental development and capacities. (2) The heart may increase its output in an attempt to maintain the peripheral circulation at a satisfactory level, but in doing so an extraordinarily large amount of blood is shunted through the ductus. Under such circumstances the individual may be relatively well developed, and, indeed, be entirely normal in appearance, and yet there is evidence of cardiac embarrassment or failure. (3) There may be superimposed upon this abnormality a bacterial infection, usually with streptococcus viridans organisms. The frequency with which bacterial infection occurs is difficult to estimate with any accuracy. It is reasonable to believe that it is found in about 25 percent of individuals who live well into adult years. (4) There are more rare complications, such as aneurysmal dilatation and rupture. The first of the above-named complications appears in childhood, whereas the others are more apt to be problems of adult life, particularly in the third and fourth decades.

The great majority of arteriovenous communications are the result of trauma. Penetrating wounds comprise the main cause, while other causes are fractured bones, technical errors during amputations, or serious contusions of vessels from external blows. Although trauma is to be considered as the main cause, there are many reports in the literature of surgery describing arteriovenous aneurysms which occurred spontaneously. Most of these have been due to rupture of an arterial aneurysm into an adjoining vein and have occurred between the aorta and the vena cava and between the pulmonary vessels. In smaller blood vessels, abscesses in the wall of an artery or a vein have eroded the concomitant vessel and thus given rise to a spontaneous arteriovenous aneurysm.

Methods of Treating Arteriovenous Communications. The essential objective for all operative procedures intended to produce permanent cure of an arteriovenous or a cirsoid aneurysm is the complete elimination of all possible pathways by which blood can find its way through an abnormal opening between an artery and a vein. The procedures which have been used and which accomplish this objective are outlined below.

Closure of Fistula with Restoration of Vein and Artery. This procedure appears at first thought to be the most ideal and the most physiologic operation. However, in many cases this operation has been followed by serious pulmonary complications, due either to air embolism or blood clots from thrombosis at the site of the operation. In addition, the enormous dilatation of the venous bed

which develops after the fistula has been established for a few weeks makes it unnecessary to restore the main vein. The ligation of the involved veins is supposed to restore a better balance between the arterial and venous circulation even when the function of the artery is re-established. We have not attempted to perform this operation.

Suturing of Fistula with Restoration of Artery and Ligation of Vein. When the arterial wall is not atrophic and no danger is anticipated from a sudden restoration of normal blood pressure, there is no objection to this procedure. The method is particularly desirable when the operation is performed early, as is frequently done in Europe, and before there has been time for the development of an adequate collateral circulation. When the operation is done many months after the injury, extensive changes have usually taken place in the proximal portion of the artery, and an extensive collateral circulation has developed spontaneously. Consequently, we do not believe it is ever advisable to attempt to reconstruct the artery. If the surgeon decides to use this operative procedure, a part of the vein can usually be used to advantage in closing the defect in the artery.

Quadruple Ligation of Artery and Vein. This will be successful only if all the intervening arterial and venous branches are ligated. This operation also carries the additional dangers of reestablishment of the circulation which follows ligation of blood vessels in continuity; this problem does not have to be considered if the vessels are ligated and divided.

Ligation of Canal of Communication. This procedure is fraught with danger of uncontrollable hemorrhage, but the greatest objection to the operation is that it is rarely possible to do it satisfactorily from the technical standpoint.

Complete Extirpation of Arteriovenous Fistula with Involved Portions of Artery and Vein. This is the operation of choice when it is possible to expose completely the site of the arteriovenous fistula. There are naturally cases in which this procedure cannot be carried out, especially when we are dealing with intracranial arteriovenous aneurysms and certain extensive cirsoid aneurysms. This operation completely removes the arteriovenous fistula; our results following it have been most satisfactory. We believe any operation which requires the use of a tourniquet should be avoided; consequently, we have had very little experience with the Matas intrasaccular restorative and obliterative operations. In a few cases where we have used a tourniquet during the operation, the subsequent control of hemorrhage after removal of the tourniquet was more troublesome than when a careful dissection of the aneurysm was carried out without a tourniquet.

Ligation and Division of Involved Vessels with Transfixion Occlusion of Fistula. This is an effective method of assuring the closure of the fistula when the hazards of total extirpation of the aneurysm are too great. If a quadruple ligation of the artery and vein has already been done, there is no danger of hemorrhage from puncturing the vein with a large needle threaded with double braided silk.

Closure of Fistula by Twisting the Divided Vein. When it is impossible to expose the vessels distal to the communication between the artery and vein, Reid has shown that the arteriovenous fistula can be closed by dividing the vein and twisting it without obstructing the lumen of the artery. This operative procedure is particularly valuable when the arteriovenous fistula is between the internal jugular and internal carotid artery near the base of the skull. In a case of a patient with an arteriovenous communication in the cavernous sinus with pulsating exophthalmos, we carefully freed the abnormally dilated and pulsating supra-orbital veins, excised the angular supra-orbital and frontal veins, and gently twisted (six revolutions) the large superior ophthalmic vein to provoke thrombosis in the vein proximally into the cavernous sinus.

Palliative Operative Procedures. In cases of abnormal arteriovenous communication of long standing, where there is clinical evidence that the heart has been badly damaged, there may be some question as to the ability of the heart muscle to withstand the physiologic changes which follow the sudden closure of such a fistula. Matas and Holman have repeatedly warned surgeons of this danger, and to permit the heart muscle to carry such an added load they have advocated repeated temporary digital compression of the fistula over a period of several weeks or months. In cases where the heart muscle is not able to tolerate sudden extirpation of the fistula even after prolonged use of this method of temporary occlusion, it is well to consider primary ligation of the **proximal vein** before any other operative procedure is undertaken for the permanent cure of the arteriovenous fistula.

SUMMARY

A review of the problems which present themselves in patients with serious arterial injuries, as well as diseases of large arteries, has been presented. This type of surgery requires special care in planning the operation and more exacting preoperative and postoperative care. The benefits which have come from the surgical treatment of congenital anomalies of large arteries are encouraging enough to make us hope for even more progress in the future in this most important field of vascular surgery.

THROMBOTIC OBLITERATION OF THE AORTIC BIFURCATION*

Frederic W. Taylor, M.D.

Leo R. Nonte, M.D.

INDIANAPOLIS

RECENTLY Leriche and Morel[1] reported a group of cases which were designated as having the syndrome of thrombotic obliteration of the aortic bifurcation. The syndrome bears none of the dramatic features of an acute aortic occlusion caused by a saddle embolus. Clinically it closely resembles the common arteriosclerotic occlusion of the great vessels of the lower extremities.

The patient is practically always a middle-aged male who complains of extreme fatigue of both legs. Intermittent claudication may be present but is not always characteristic. A varying degree of pain is always found. This may be constant and severe or intermittent and less prominent. The authors make quite a point of impotency, which is often present.

The physical findings are not unlike those found in the various stages of arterial insufficiency of the lower extremities. The important and diagnostic exception is the *absence of an iliac or femoral pulse.* At the onset this may be unilateral but eventually becomes bilateral. The oscillometric readings are practically zero. There is usually considerable atrophy of the legs without trophic skin changes. Pallor of the legs and feet is said to be characteristic although it was not in the case here reported. Possibly this is because our case was far advanced with impending gangrene.

The pathologic sequence of events in these cases is thought to start as a thrombosis of the common iliac arteries. This extends upward to reach the aorta. It is thought that the thrombus extends to obliterate the other common iliac vessel only after a considerable period of time, thus allowing an opportunity for a collateral blood supply to become effective. The final result is an obliteration of both iliacs and the aortic bifurcation. Undoubtedly a varying degree of recanalization of the thrombus takes place in all these cases.

Treatment of patients bearing this syndrome has been directed toward increasing the collateral circulation of the extremities. This has been accomplished through lumbar sympathectomies. A few aortectomies have been done with bilateral sympathectomy. The rationale of excising the aorta and its bifurcation seems open to some question.

The results obtained by sympathectomy and sympathectomy plus aortectomy have not been universally good. The patient may go on to lose one leg and occasionally both. Usually there is, however, considerable temporary or permanent improvement in the circulation of the extremities with diminished pain.

Since we had never diagnosed or seen a case of thrombotic obliteration of the aorta the study of the patient here reported was entered upon with considerable skepticism. Having completed the study, it seems quite probable that its appearance may be by no means rare. It is logical to assume that an occasional case of Buergers disease or extremity arteriosclerosis may progress to aortic thrombosis.

Quite a number of cases have been reported since Leriche[2] brought attention to the syndrome eight years ago. Many of these have had acute onsets which immediately point to a violent and sudden occlusion of the aorta. Others have had a chronic course with little to suggest that the blood flow had been cut off in the aorta; such as those cases of Leriche and the one here detailed.

Most of the cases in the American literature have been of the acute occlusive type.[3, 4, 5, 6, 7, 8] Since the chronic form of the disease is a seldom considered possibility in peripheral vascular disease, a resumé of the following case seems justified.

CASE REPORT

Register No. 40892. A forty-eight-year-old, white man was admitted to the hospital on the night of April 7, 1948. He complained of severe pain in the first and second toes of the right foot. His history revealed that he had had intermittent claudication for the past three years. For three months this had been more pronounced in the right leg. Three weeks prior to admission he started to have severe pain in the first and second toes of the right foot. It was noted that these two toes began to change to a dusky blue color. The pain continued to increase and he sought hospitalization.

Past History: The patient complained of an impotency of seven years' duration. The degree was not stated. He had had a gunshot wound of the left heel in service in 1918. This was followed by

* From Veterans Hospital, Cold Springs Road, Indianapolis.

phlebitis of the left leg with moderate residual symptoms. Occasionally there was swelling of the left leg, necessitating the use of an elastic stocking. He had lost some thirty pounds in weight during the past year.

Physical Examination: The patient appeared older than his stated age of forty-eight. He was nearly six feet tall and weighed 141 pounds. The patient was very nervous and appeared to be in extreme pain. Pertinent findings included a blood pressure of 170/90. No evidence of organic heart disease was noted.

Extremities: No pulsation could be found in either right or left femoral, popliteal, anterior or posterior tibial arteries. Both lower extremities were cold. Toes of the right foot, especially the first and second, were cyanotic and very tender. Vein-filling time for the dorsum of the right foot was one minute, and two minutes for the vein from the great toe. The veins emptied immediately when the extremity was elevated. Oscillometric reading for the right calf was 0, right thigh 0 to ¼, left calf 0 to ¼, left thigh 0 to ½.

Laboratory: The blood picture was within normal range. Urine was negative. Serology negative. Fasting blood sugar 55 mg.

Course: Upon admission the patient was given intravenously 300 mg. of tetraethyl ammonium chloride. Blood pressure fell from 170/90 to 150/90. The patient experienced no immediate relief but after twenty minutes he stated that the right foot felt better than it had for many days. The following morning the patient received an intravenous drip of tetraethyl ammonium chloride over a period of three hours (1 gram in 500 cc. saline). This resulted in no appreciable change in his condition.

The following two days the patient again received intravenous tetraethyl ammonium chloride and intravenous ether (25 cc. in 1,000 cc. saline). Since this therapy was ineffective in giving relief of pain or aiding the local situation, it was discontinued. The pain was so severe that in order to avoid excessive use of opiates, nerve section was done on the peroneal and anterior tibial nerves. This was only partially effective. A right lumbar sympathectomy was advised but was refused by the patient.

During this time the offending toes remained discolored but did not actually become gangrenous. Because of our failure to change the local condition for the better, and at the constant pleas of the patient for removal of the offending member, a Gritti-Stokes amputation was done April 24, 1948. At the time of operation there was no bleeding from the major blood vessels. (Figure 1.) In fact, the blood flow was so slight that we feared that the amputation had not been done at a sufficiently high level. However, wound healing was uninterrupted.

The patient had relief from pain for a few days and then complained bitterly of pain in the phantom limb. The degree of this pain was difficult to evaluate because of the patient's mental makeup. He was allowed to go home, in the hope that this would aid.

On May 24, 1948, he was again readmitted for extreme pain in the phantom right foot. Three days later he consented to a bilateral lumbar sympathectomy.

Figure 1

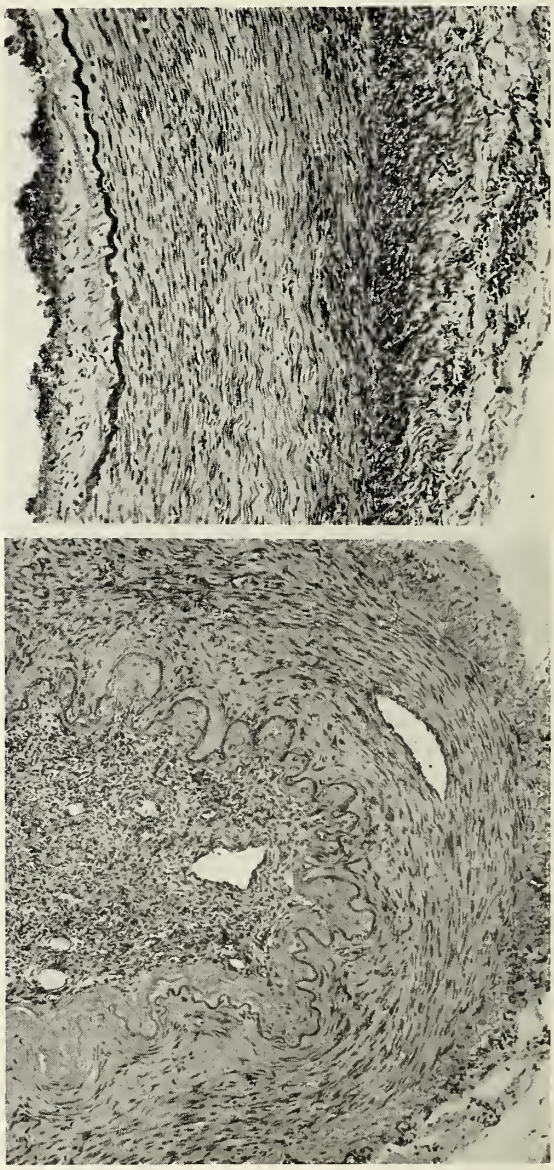

Figure 1. Tibial artery of amputated leg showing intimal thickening and moderate inflammatory reaction in adventitia. Lower photomicrograph shows part of an organizing thrombus in a vein of the same region.

OPERATION

At this operation the sympathetic chain and what were considered to be the third and fourth lumbar ganglia were removed from each side. During this surgical procedure the lower aorta was thoroughly explored. The distal three inches of this vessel was hard and completely devoid of any arterial pulsation. This was considered as complete thrombosis extending down and including the bifurcation. On the left the common iliac was exposed. It was cord-like and no pulsation could be demonstrated. The right common iliac was not exposed but it was assumed that the thrombus of the bifurcation extended down into it for an unknown distance. Just below the aortic branches to the kidneys the aorta was elastic, soft, and pulsated normally. (Figure 2.)

Postoperatively the patient did well and was fairly comfortable. He then again started to have severe pain of the phantom right foot. Several novocaine-alcohol injections of the sciatic nerve have been given with temporary improvement. The psychological element is so great in this patient it is difficult to evaluate the therapy given for the phantom foot syndrome. To date it has not been solved although from an anatomical standpoint the left leg and the amputated stump are in excellent condition. (Figure 3.)

COMMENT

A resumé of a patient presenting the syndrome of thrombotic obliteration of the aortic bifurcation is reported. The terminal aorta was found at operation (bilateral lumbar sympathectomy) to be completely obliterated supposedly by a thrombus. When this case was first seen it was considered to be one of Buergers disease or arteriosclerosis of the vessels of the legs. The thought naturally occurs that possibly in the past some of our patients with Buergers disease or arteriosclerosis

Figure 2

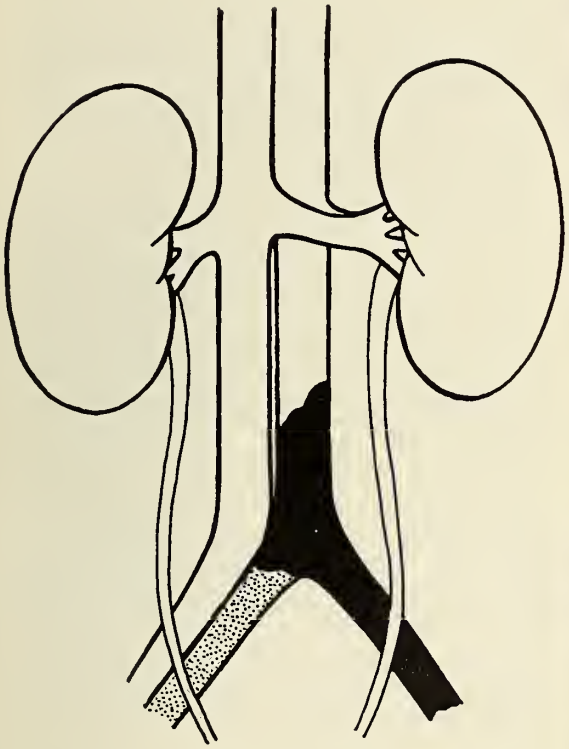

Figure 2. Diagrammatic representation of findings noted at time of bilateral sympathectomy. The aorta and its bifurcation were filled with a firm mass which was devoid of pulsation. This extended down into the left common iliac artery as indicated (black). It is assumed that the thrombus extended into the right common iliac although this area was not explored at time of surgery (stippled). Three inches above the bifurcation the aorta was resilient and pulsated normally.

Figure 3

Figure 3. Three weeks after bilateral lumbar sympathectomy the amputation stump was healed and there was considerable improvement in the left leg circulation.

resulting in gangrene, also may have had a superimposed thrombotic obliteration of the aortic bifurcation.

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TUMOR OF THE PINEAL BODY WITH HIGH INSULIN RESISTANCE

EDGAR N. MENDENHALL, M.D.

FORT WAYNE

THIS report has been prepared for the following reasons:

1—To report a very unusual definite clinical syndrome in three children in one family which, as far as I am able to ascertain, has not been previously reported.

2—To suggest the possibility of some internal secretion of the pineal body and to stimulate study of the effect this gland may have on carbohydrate metabolism.

These cases are of interest not only from an endocrine viewpoint, but also from the viewpoint of heredity.

This family consisted of normal, white, American parents and seven children. The first and third children (both girls) are normal in every respect, while the second, fourth and seventh child had the syndrome described later. The fifth child had the same physical characteristics but died from an intussusception at the age of six months, not having lived long enough to develop diabetes. The sixth child was born an anencephalic and died a few days after birth. It had none of the stigmata of the others. I know most of the relatives personally. All are normal. The only thing in the family history that might be pertinent is that the maternal grandmother had diabetes and died of pulmonary tuberculosis. The mother and her two daughters have a slightly increased amount of hair on their arms and legs. I have delivered a normal girl and boy for the oldest daughter and a normal boy for the other normal daughter.

The syndrome to be described consists of a congenital defect characterized by:

1—An old-appearing face with heavy features.
2—Hirsutism. (Fine hair over body, coarse hair over arms, legs and head.)
3—Pigmented skin; rough and thicker than normal for a child.
4—Protruding abdomen.
5—Thickened and hardened fingernails and toenails.
6—Early dentition. (First dentition complete at one year, second dentition at two to three years.)
7—Enlarged external genitalia in both the male and female.
8—Hyperglycemia, highly resistant to insulin at age of seven.
9—Death from infection or some concomitant cause.

The first child to die (the fifth birth in the family) died as the result of an intussusception. An autopsy was performed but, unfortunately, the skull was not opened, for at that time I did not realize the possibility of the pineal or pituitary having an influence on the clinical aspect. No abnormality was found, grossly or microscopically, except the intussusception.

CASE I

The first of the abnormal children to reach the age when diabetes appeared presented some of the characteristics of this syndrome at birth. This child was a girl, the second birth in the family. At the age of two months she had her first tooth. The remaining primary dentition came in after she was four months of age. The second dentition erupted when she was two, her ten-year molars when she was four years of age.

At the age of six months a tumor of the left ovary, the size of a naval orange, was removed. This was called a sarcoma by Doctor Ewing.

Polydipsia and polyuria at the age of three years prompted a urinalysis, in which sugar was found. After a few days of low carbohydrate diet the sugar and symptoms disappeared, until the age of seven. In the meantime she took regular diet.

She had measles and whooping cough at the age of five, with normal recovery. At six years of age I removed her tonsils. At that time she had no sugar in her urine and she recovered without complications.

At the age of eight small abscesses appeared near the rectum and on her legs. For a short time she had been complaining of headache and drowsiness. A urine examination showed a very high percentage of sugar. Because of her age and high blood sugar (450 mgm. %), I referred her to Dr. John Warvel of Indianapolis. Doctor Warvel hospitalized her the first time from January 8 to February 16, 1934. His examination at that time showed normal B.M.R.; N.P.N.; blood count and blood cholesterol; urine, ketosis; glycosuria and trace of albumin; blood sugar 250-570; x-ray examination showed infected sinus, large colon; calcification of bones normal for her age; sella turcica normal. She was given adrenalin, to which she was quite sensitive; pituitrin and cortin with no reaction or influence on the sugar. She had a constant sugar waste regardless of diet or insulin. She was discharged with no definite diagnosis.

She was again admitted to the hospital April 25 to 27, 1934, with no change in findings. While in the hospital she was given a diet of about 1,100 calories with varying amounts of insulin, the largest amount being 50 units of regular insulin at 2:00 A.M. and 100 units t.i.d.a.c. That day the blood sugar was 226 mgm. %, and a urinary wastage of 84 gm. of glucose out of 132 gms. available.

She was returned home and, despite a diabetic diet and insulin, continued with her waste of carbohydrates. In November she contracted a cold, the following day developed pneumonia, and died in about seven hours.

The autopsy was performed by the pathologist of the Methodist Hospital, Indianapolis. The essential findings besides the bronchial pneumonia were:

1—Early involution of thymus.

2—Atypical development of the Graafian follicles.

3—Cyst of the pituitary.

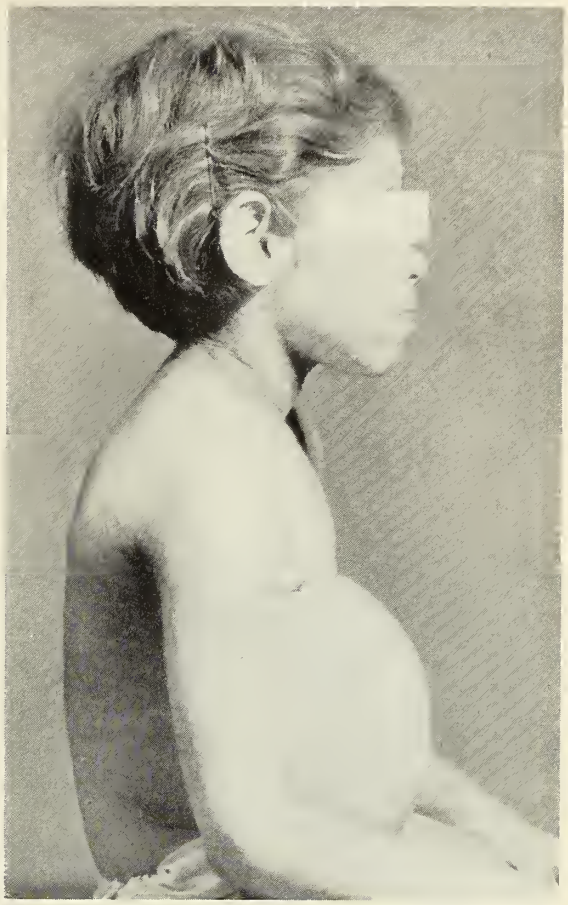
4—Congenital abnormality of right kidney.

5—Fibrosis of island of Langerhans of pancreas.

6—Tumor of pineal gland (pinealoma).

The liver and adrenals were normal.

Figure I



The older girl at age of seven.

CASE II

The second child of this series was a boy who, from birth, had the physical characteristics of his older sister. Because of this, when his sister was hospitalized I referred him to Doctor Warvel. At that time he was four years of age. A glucose tolerance test was run, which was normal.

At intervals after his return home I examined his urine. At the age of seven sugar appeared in his urine for the first time. He was again referred to Doctor Warvel, who had him under observation from June 11 to August 6, 1939.

All x-rays and laboratory tests were negative for pathological conditions except for sugar. His blood sugar varied from 176 to 440 mgm. %, irrespective of the amount of insulin given.

Various diets and amounts of insulin were tried. Special 500 U. insulin was made. At one time he was given 300 units of regular insulin before breakfast, 500 units at noon, and his blood sugar at 4:00 P.M. was 180 mgm. At another time he was given 1,000 units of regular insulin at noon in a single injection, and at 4:00 P.M. his blood sugar was 260 mgm.%.

The boy was returned home unimproved.

In December, 1939 the child had bronchitis. He was hospitalized at the first symptom but developed an acidosis. He received large amounts of insulin, with no effect. In an attempt to combat this condition he was given 350 to 500 units of insulin every two to three hours. The hospital records show only 4,900 units in twenty-four hours, but one dose of 500 units failed to be recorded. The blood sugar dropped from 280 mgm. to 57.8 mgm. %. With slight insulin shock, glucose was given and immediately the blood sugar rose to 170. The boy died the following day.

An autopsy performed by Dr. N. Velkoff, the St. Joseph Hospital Pathologist at that time, reported:

Figure II

The boy at age of four.

1—Hemangioma of the brain.

2—Pinealoma, measuring 2x2x1 cm.

3—Normal thyroid.

4—Normal thymus.

5—Normal adrenal.

6—Normal liver.

7—Pituitary gland shows marked vascular hyperemia.

8—Pancreas island of Langerhans hypertrophic with signs of fibrotic changes and no tumor formations.

CASE III

The last of these children died in October, 1947. I watched her carefully from birth because her appearance was identical with the other two abnormal children.

She weighed five and one-half pounds at birth. She had her first tooth at three months, and most of her teeth when a year old. The second dentition began appearing in her second year and all the teeth were erupted by the time she was three. The dentist informs me she had her ten-year molars at the age of four.

She had the potbelly and an excess of hair over her body. The hair on her head was very heavy and long. A picture of her standing, at the age of six, shows her hair reaching below her knees. She sat up by herself at the age of six months, crawled at eight months, and walked when just over a year old. She grew normally until about two and one-half to three years, when her skin began to wrinkle, her face took on more of an appearance of age and her skin became pigmented. Her fingernails became harder and her toenails became so hard and thick (⅜ inch) that it was almost impossible to cut them.

The labia majora and minora became large and her clitoris was the size of that of an adult.

Whooping cough and chickenpox at the age of four to five, with uneventful recovery, seemed not to influence her other condition in any way.

The tonsils and adenoids were large and obstructed her breathing, but I feared to remove them. All the teeth were decayed and some that were badly infected were extracted. The tongue was thick and, because of the mouth breathing, rather dry and furrowed.

When she was five and one-half years of age she entered school and was a very bright pupil; her mental age was above that of the other children. Her sight was good. Her weight was about normal for her age, though the stature was less than the average, yet hardly enough to be a dwarf (3 feet 1½ inches).

The urine was examined, and until the age of seven showed no abnormality.

Figure III

The younger girl at age of five.

In September, 1946 her mother noticed she drank more water and urination become more frequent. A urinalysis showed 4 plus sugar. This condition could have appeared only a short time before, for the parents, expecting this to happen, kept a careful check. She began to complain of headaches about this time.

This child was also referred to Doctor Warvel. She was hospitalized for several days. The findings were the same as mine, but to determine her insulin resistance 1,000 units of insulin was given at one time and 500 units at another, with little effect on the blood sugar.

Upon her return home she re-entered school and continued all activities until early October the following year, when she developed pyelonephritis and died from septicemia. The essential pathological findings of Dr. S. M. Rabson, St. Joseph Hospital Pathologist, were:

1—Hypertrophy of pancreas with severe fibrosis.

2—Simple cyst of the pituitary.

3—Hyperplasia of the pineal gland (measuring 3x2x1 cm.).

4—Perinephric abscess, bilateral.

5—Abscesses of the kidney.

SUMMARY

A report is given of three proven cases of tumor of the pineal body, two of them with cysts of the pituitary, with a definite clinical syndrome ending with a high insulin resistance and death.

COMMENT

These cases are unusually interesting from the standpoint of heredity, since the first and third children of the family are normal and have normal children, while the other children of the family had these glandular defects.

They are interesting from a standpoint of endocrinology, in that all the glands in these children were normal except the pituitary, pancreas and pineal; therefore, the symptoms must spring from the defects of these glands.

Tumors and cysts of the pituitary are not very rare and the symptoms are well-known.

Practically nothing is known of the pineal gland. Some authorities say it has no function while others disagree. Even its embryonic derivation is questioned, some believing it a remnant of a third eye.

Davis and Martin[1] say: "Among the organs of the body the physiology of which remains incompletely understood, no one structure has caused more diversity of opinion or argumentative disagreement than the pineal gland."

The microscopic sections of the pineal in all were identical. The diagnosis by the pathologists was pinealoma.

The symptoms generally given for tumors of the pineal gland are pressure or invasion symptoms, such as ocular manifestations, projectile vomiting, headache, mental changes, disturbance in heat and water metabolism. Other symptoms given for tumors of the pineal gland are those of Pellizzi's syndrome,[2] which are:

1—Precocious development of external genitalia with premature appearance of pubic and axillary hair.

2—Precocious development of sex functions.

3—Precocious abnormal growth of long bones.

4—Appearance of symptoms of internal hydrocephalus, including headache, vomiting, choked disc and optic atrophy.

5—Absence of other motor and sensory symptoms.

These children had the precocious external genital development, the abnormal hair, and the absence of motor and sensory disturbances, but none of the other symptoms included in the Pellizzi syndrome were evident. The other symptoms usually given were not present in these cases I am reporting.

Some of the symptoms of these children could be laid to the cyst of the pituitary, but it is unlikely that hirsutism, the early dentition, or some of the skin, hair and nail abnormalities could be due to this.

In reference to the insulin resistance, the secretion of the anterior pituitary acts to inhibit insulin metabolism of carbohydrates, but in these cases the pituitary cells were normal or destroyed by the cysts. When there is a destruction of the anterior pituitary, a hypoglycemia appears, while the opposite appears here. This suggests the possibility of the pineal gland having some active part in carbohydrate metabolism.

Comparatively little experimental work has been done on this gland. Dr. C. H. Best, in a letter to me in reference to my inquiry about these cases, writes "I know of no good evidence the pineal is related in any way to diabetes. Secondary effects on the pituitary or the hypothalmus might be exerted from the pineal tumor. On the other hand, you are quite right that further work on the pineal in relation to carbohydrate metabolism is indicated. Very little has been done."

ADDENDUM

These unusual cases have led me into a series of experiments to establish a possible relation between blood sugar and the pineal gland. The result of the research which I have done over a period of months in the Fort Wayne Medical Laboratory are encouraging. A report of the result of this research will be made later.

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2. Pellizzi, G. B.: Riv. ital. di neuropat 1910, iii, 193.

A Program Every Doctor Should Hear!

You can spend a profitable and enjoyable day attending the annual CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS at the Claypool hotel in Indianapolis on Sunday, January 29. A copy of the program, including a luncheon reservation card, was sent you in the January I.S.M.A. News Flashes. The program begins at 10 a. m. and ends at 3:30 p. m.

The principal speaker at the luncheon will be Attorney Russell I. Richardson of Lebanon, who recently spent a month in England studying conditions there. His subject is: "British Socialism: Do We Want It Here?" Every doctor should hear Mr. Richardson's first-hand report on socialized medicine as it is operating in Britain today.

Thomas A. Hendricks, former executive secretary of I.S.M.A., and now secretary of the A.M.A. Council on Medical Service, will tell what's going on at the A.M.A. Tom will explain A.M.A. plans for fighting socialized medicine.

The program includes other interesting papers. Get up a party of your friends and attend. It will be well worth your while. So we'll have a place for you, be sure to mail in your luncheon reservation.

Committee on Conference of County Medical
Society Officers

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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Office of Publication: 1017 Hume Mansur Building

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Editor Emeritus: E. M. Shanklin, M.D., Hammond, Indiana

Editor: Frank B. Ramsey, M.D., 201 Hume Mansur Building, Indianapolis 4, Indiana
Associate Editor: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana
Managing Editor: Ray E. Smith, 1017 Hume Mansur Building, Indianapolis 4, Indiana
Editorial Secretary: Mrs. Isabella Rowlison, 1017 Hume Mansur Building, Indianapolis 4, Indiana

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GRASS ROOTS

THE Education Campaign of the A.M.A. has now been functioning for one year under the directorship of Whitaker and Baxter. In that time it has achieved a sound beginning and has attracted a great many citizens and public-spirited organizations to its support.

The campaign has been conducted in such a way as to enlist not only the services of the medical profession, but also the cooperation and interest of countless friends of free medicine. Those in charge of the campaign have found that there is a widespread and active interest in good medical care. Much of the educational effort has been utilized to provide information to the people to enable them to decide how the best medical care can be made available.

By encouraging national and local civic organizations to place themselves on record, the medical profession has been able to impress our legislators with the great mass of public opinion which exists against political medicine. During the past few months the campaign has moved from a stage in which consideration of national legislation was imminent to one in which the question was not even debated.

During the summer months there were rumors that the question of compulsory health insurance would be made a campaign issue. We have now passed the rumor stage and recently there have been several authoritative announcements to the effect that political medicine will be a major, or possibly the prime issue in the 1950 elections.

Such a development increases the necessity for renewed efforts on behalf of free medicine, and it has the advantage of bringing the entire discussion to a more decisive phase. There is little doubt that much of the clamor for compulsory insurance has arisen from an extremely small minority of professional rabble-rousers and do-gooders. The A.M.A. campaign experience indicates that there are millions of people in this country who want no part of government medicine.

The medical profession will welcome an opportunity to decide the question by popular vote. This is the way issues should be settled in a democracy, and there are indications that the electorate is anxious to express its opinion in this way. Two recent by-elections attracted national comment because each was won by the candidate (one Democratic and the other Republican) who had publicly announced his opposition to compulsory health insurance.

In order to make the election as democratic as possible it will be necessary to provide information for the voters. The A.M.A. Education Cam-

paign has made a good beginning, but there are still many people to be reached. A continuation and intensification of our educational effort is now being called for.

One of the duties of a doctor as a citizen is the duty to vote. Another duty which falls to us as doctors is the duty to inform the people so that they may vote intelligently on medical matters. Now, when the freedom of medicine is threatened, these duties are paramount.

BRITISH HEALTH SERVICE?

IN a guest editorial written by Dr. William H. Sweet of Boston for the *Virginia Medical Monthly* appears the statement that a medical book representative of a prominent British publishing firm has recently made a trip about the country to see "why people were not buying medical books." He found that "the medical profession is full of unrest, is decidedly poorer than it has ever been before . . . and just has not got the money to spare for books."

In the same editorial it is stated that from 50 to 100 home and office cases is the current quota for many British physicians.

The British Health Service has created two kinds of doctors. One is the physician who has signed up only the number of patients to which he is able to render good and conscientious service. Since his income is proportional to the number of patients registered with him, this physician's income is low, and many of his type are borrowing money on which to exist.

Other British physicians are burdened with the maximum number of patients allowed by law. Their incomes are higher, but their medical responsibilities are staggering. With as many as 80 patients to be seen during office hours, each patient can be allowed only a few minutes.

It is understandable that the doctor who is not able to support himself and his family will not be able to purchase medical books.

However, there must be other reasons why the sale of medical books has suffered a sudden decline in England. Some of the doctors with large panels must surely be able to afford a few of the new publications. The irony of it is that these men are so overworked that they have no time for reading, and also have no incentive for improving their own knowledge.

One does not need to keep abreast of the advances in medicine to be able to write a prescription for symptomatic treatment of a patient for whom no more than a three-minute consultation can be allowed.

The medical information derived by the doctor in a three-minute history and physical examination must not lead very deeply into the intricacies of diagnosis. If these overworked doctors ever had time to read a new medical book, it would be impossible for them to utilize their knowledge.

It is easy to understand why medical books are not selling in Great Britain.

Editorial Notes

The PR Doctor, of November 25, 1949, issued by the Public Relations Department of the American Medical Association, had the following words of praise for our centennial meeting:

INDIANA CENTENNIAL IS BANG-UP SUCCESS

Indiana State Medical Association's Centennial convention, September 26-29, was a gala occasion for the medical profession in the state, and also provided a golden opportunity for good public relations.

One of the chief PR highlights of the meeting was the opening of the exhibit hall to the public. Indiana doctors prepared an outstanding historical exhibit. Space also was allowed for county societies to display samples of their public relations activities. Theme of these and other booths was the great progress of medicine under a free system.

Both Indianapolis newspapers printed special medical sections during the meeting, providing an opportunity for constructive medical news stories and for congratulatory advertising by business firms and institutions. The state medical society took ads to publicize the convention exhibits and to reemphasize the progress of American medicine "free from government shackles."

Indiana State Medical Association's Woman's Auxiliary contributed its public relations touch by conferring honorary membership on Mrs. Henry F. Schricker, wife of the Indiana governor and the daughter of a doctor.

State societies with 100th anniversary celebrations coming up would do well to obtain a complete report from Indiana on its well-planned and very successful meeting.

The Pennsylvania Medical Journal for November, 1949 made the following laudatory comment:

INDIANA STATE MEDICAL SOCIETY CELEBRATES ITS CENTENNIAL

President E. Roger Samuel represented our society at the centennial celebration of the Indiana State Medical Association in September. He is enthusiastic in his praise of not only the dinner and program of the meeting, which he and a thousand others attended, but also of the many hospitable courtesies shown him.

The convention issue of the monthly *Journal of the Indiana State Medical Association,* with its handsome cover page in gold, black, and white, is replete throughout its one hundred and seventy-five pages with interesting historical articles, scientific papers, editorials, and programs which record medical progress, health and welfare responsibilities discharged, research, preventive medicine and public health—all done for the benefit of the people of Indiana as only an alert professional organization can do.

Eleven thousand members of The Medical Society of the State of Pennsylvania will echo the congratulations and good wishes which President Samuel expressed in person on Sept. 29, 1949, in Indianapolis.

Medical Panorama by the Associate Editor

The following editorial appeared in *The Journal of the Kansas Medical Society* for September 1949. Only parts can be quoted, but we think you will be interested:

AN OPEN LETTER TO MR. BEVAN

Mr. Aneurin Bevan, you may recall a conversation you had with John W. McPherrin, editor of *The American Druggist,* in your London office. In the July, 1949, issue of that journal, he quotes the following of your conversation concerning medicine. Do you wish to read it to make certain the statements are accurate?

"Most people trust their individual doctors. At least they trust them more than they do organized medicine, the associations of doctors. When a doctor becomes a member of an organized group something seems to happen to his thinking. Did you ever notice that? It is quite a phenomenon.

"The mental change that comes over a doctor when he functions as a member of organized medicine is unbelievable. It ought to be the subject of psychological research. You know that organized medicine has always been arrogant, always on the defensive. What are these doctors afraid of? Maybe they have an inferiority complex of some kind. It is all very surprising because, as individuals, doctors most of them, enjoy the faith and confidence of the public."

Group thinking should not be so "very surprising" to you, Mr. Bevan. Without labor thinking as a group, there might have been some other Minister of Health in Great Britain, or is that too naive to be polite? Furthermore, the administration of socialized medicine requires that a large segment of the population think as a group, and directing that thought is certainly one of your duties. In America we speak of such tactics as propaganda but to the Minister of Health of Britain's labor party we suspect it would not sound discreet.

Anyway, it seems strange that group thinking should contain any mysteries for you. Could it be that a group of doctors think differently from other groups and that it is the doctor himself you do not understand? You have seen him, perhaps, only as a professional man caring for the illness of an individual patient. Then you think he is quite all right.

* * * * *

We try to recommend whatever we think as a group would be best for the health of the people, and group thinking incidentally, represents the majority opinion of the members present, as I suspect it does in the British Medical Association.

Now, that should not be so "unbelievable" except to someone who has not been accustomed to abiding by majority opinion, but surely you learned that in public office if not before. So the only remaining mystery is why should group thinking concern itself with benefits for those not in the group.

If that is any problem at all, Mr. Bevan, then it is admittedly hard to explain. Doctors whose whole professional activity centers around service for others just continue to think that way as a group. The Kansas Medical Society will oppose a system of socialized medicine for the same reasons, I am sure, that the British association dislikes your plan, because they know it is not best for the people and for the nation. It is economically unsound, we believe, and destroys freedom and individual initiative. In America, we still place a value on that. Then, last but not by any means least, a system such as yours is not best for the health of the people. We can demonstrate that but this letter is long enough already.

If you find it in your heart to believe that an organization can exist which has public service as its major objective, then surely understanding organized medicine is no more difficult than understanding the motives that direct the activities of your personal physician.

To which we would have the choir sing a sevenfold Amen.

"As The English See Us"

Under the above title *Philadelphia Medicine*, in its October 15, 1949, number, published the following, which needs no comment from us, except that you should read it:

During the past summer a number of British doctors visited our Philadelphia hospitals and, later, attended the A.M.A. Convention in Atlantic City.

It was our good fortune to meet several of these men, all of whom were impressed by American medical achievement—and said so quite frankly. One young English surgeon was able, through the generosity of Philadelphia acquaintances, to obtain samples of some of the latest drugs manufactured here. His gratitude and enthusiasm were right from the heart. He said of one product,

"If I can get only the *literature* on it I'll consider myself lucky."

And he summed up his opinion of American medicine with these words,

"You are so far ahead of us!

"We have nothing at home to compare with your progress. We have neither the facilities for research nor the enterprise to carry it out—and Aneurin Bevan has made slaves of us for the socialistic state."

One cannot help but wonder what he would think if he had heard President Truman's speech on September 27, marking Democratic Women's Day. It would seem the Chief Executive doesn't share our English friend's admiration for American medicine. According to Mr. Truman we are "160 years behind the times."

Compounded of half-truths, double-talk and distortion, his address blasted Americans for daring to criticize his proposed "welfare state," and he sneeringly declared we should "act promptly to improve the health of the Nation." This tirade does not frighten American doctors who are in the best position to know that Americans enjoy better health than any people on the face of the earth.

Indeed there is something to be learned from the Presidential outburst. We can learn to be everlastingly on our guard against Mr. Truman's persistency. For he is a determined man and has no intention of abandoning compulsory health insurance. He says,

"I will go ahead with my plans in spite of the outcries of certain people."

He is going to shove his program down America's throat—if he can. It is the same dose that is helping to bankrupt England.

The best way to defeat this, and to defend our American freedom, is by telling the people the truth. The facts about socialized medicine—particularly how it would affect the average citizen—are available . . . put them into the hands of your patients, your friends and your elected representatives. Mr. Truman will sometimes listen to the latter, even if he ignores the rest of us.

President's Page

THE DOCTOR AND THE NEW YEAR

A BRAND new year has been ushered into the picture, but the same old face that was so prominent in the 1949 album—Socialized Medicine—is still showing.

This new year, 1950, is an election year. Will 1950 see the same faces returned to Congress? Every one of you lives in a Congressional district. How much do you know about your Congressman? Do you know if he backs President Truman's plan for a welfare state?

It was Lenin who said, "Socialized medicine is the keystone of the arch of the welfare state." Now, is a welfare state concerned with anyone as an individual? No. Anyone as a professional man or woman? Much less so. One purpose of national socialization, or the welfare state, is to use you—the physician, the surgeon, the specialist—as a skilled worker on a skilled worker's wages. Do you want that?

Our only hope in avoiding this subjugation of self to the state is to maintain the people's control of our legislative bodies. When we send a man to Congress, let's be sure he will represent the ideals we entrust to his care. His convictions must reflect our own, and he must be a man who can maintain the courage of those convictions. Remember, your life and your livelihood go into your vote. This is no time to think you have done enough by just getting to the polls on election day. The primaries are coming; this is the time to get a man or a woman on your party ticket who will represent the American people and the American way.

E. S. Black,

DUES WILL PROVIDE A.M.A. WITH FUNDS TO FIGHT SOCIALIZED MEDICINE ON BROAD FRONT

A. S. Giordano, M.D.*

SOUTH BEND

"WE HAVE NOT yet begun to fight!" This courageous reply of Captain John Paul Jones to the surrender demand of the commander of a British man-of-war during a naval engagement in the Revolutionary War is, in effect, what the American Medical Association said to proponents of compulsory health insurance by its action at the Clinical Session in Washington last month.

By his dogged determination to fight, Captain Jones eventually won the battle. American medicine elected to continue the fight by voting $25 annual dues for active members of the A.M.A., the money to supply the ammunition to oppose the socialist state in general and socialized medicine in particular. Results to date have been good; ultimate victory is anticipated.

Plans for the 1950 campaign will be outlined by Whitaker & Baxter, public relations firm engaged by the American Medical Association to direct the fight, at a meeting of representatives from state and territorial medical associations in Chicago Sunday, February 12. In a report to the A.M.A. delegates at Washington, the Coordinating Committee said, in part:

"The basic objectives are the same as in the beginning—to present the case for decent medical standards under a voluntary system, on the basis of facts and truth, before the bar of public opinion. The campaign techniques will be unchanged. The appeal and the media will be broadened tenfold. The political battle will be accepted and fought out in the best American tradition on every front."

Constructive assistance will be given to voluntary health insurance plans to enlarge and improve them.

FIRST A.M.A. DUES IN HISTORY

By voting unanimously to establish annual dues, the American Medical Association broke a precedent by requiring dues for the first time in its 103-year history. Membership previously became automatic in the A.M.A. when a physician joined his local county medical society. The payment of $25 will make him an active member. If he wants to be a Fellow in addition, he will pay another $12 a year, but he will get *The Journal*. Any physician may subscribe for *The Journal* by paying the $12 subscription price. The $25 dues are deductible from income tax; the $25 assessment in 1949 was not. Nearly 2,600 Indiana doctors paid the assessment in 1949.

SALIENT STATEMENTS BY A.M.A. LEADERS

"The American Medical Association's educational campaign has reached only a fraction of its projected power. It must be continued until the threat of the welfare state and socialism is completely stamped out. Every physician must enter the fight for preservation and continuing improvement of medical care of the people. Even more is the preservation of American freedom and free enterprise now assailed by a ruinous socialism which has failed and is failing before our eyes in Europe."—*Dr. Ernest E. Irons, president of the American Medical Association.*

"President Truman and Federal Security Administrator Oscar Ewing have announced they intend to carry this issue (socialized medicine) into the Congressional campaigns in 1950. Let's not be hesitant about accepting that challenge. We have forced our opponent to drop their plans for a blitzkreig in Congress—and to submit their case to the people. Now let's meet them in the grass roots . . . and let the people decide, by their ballots, whether they want socialized medicine in America."—*Dr. Elmer L. Henderson, president-elect of the American Medical Association.*

"The British doctors lost their fight against socialization because they didn't stick together. Let us not make the same mistake in this country."—*Dr. Louis H. Bauer, chairman of A.M.A. Board of Trustees.*

"There are only two places where socialized medicine will work. One is Heaven, where they don't need it, and the other is Hell, where they already have it."—*Dr. Andy Hall, 84-year-old Mount Vernon, Illinois, physician, who was named general practitioner of the year.*

The A.M.A. membership is not "compulsory" as said in the press. If a doctor wants to be a member of the American Medical Association he will pay dues the same as he would in any organization. Whether he takes out A.M.A. membership and helps to support it and its activities is entirely voluntary upon his part unless his county medical society requires it, as is the case in Marion county.

* A Delegate from the Indiana State Medical Association to the House of Delegates of the American Medical Association.

The income from the dues, expected to be about $3,000,000 a year, will be used, as stated, to continue the national education campaign and to meet the constantly increasing responsibilities of the A.M.A. on a broad front. Until now the A.M.A. has operated largely on profits from *The Journal* and its other publications. In 1948 *The Journal* had a total income of $1,767,425 and a total net expenditure of $1,368,455, leaving a balance of $395,970. The balance was much lower in 1949, and *The Journal* does not expect to more than break even in 1950, it was said.

After the A.M.A. Constitution and By-Laws were amended to provide dues, the Board of Trustees recommended they be $25 annually. There was no opposition to the amount, but a move by New York for the A.M.A. to collect the dues directly was defeated. The secretary of the county medical society will collect the dues, send them to state headquarters, which will forward them to Chicago. After a year's delinquency, a member will be notified, and if he fails to pay his dues in thirty days, he will be dropped. An active member is to be provided with a pocket card or certificate of membership. Honorary members, senior members, interns, residents, and members not actively engaged in practice will be excused from dues on recommendation by the secretary of the county medical society.

Another By-Laws change compels a member to hold membership in the constituent society in the jurisdiction of which he practices. If he moves to another jurisdiction, he has six months to transfer his membership after the change. If he fails to do so, his name will be removed from the A.M.A. roster.

U.S. AIR FORCE VOTED REPRESENTATION

The Constitution was amended to give the United States Air Force representation in the House of Delegates. The United States Army. United States Navy, United States Public Health Service and Veterans Administration each have had a delegate.

WILL RESTUDY "HESS REPORT"

The so-called "Hess Report" which deals with rules relative to hospitals practicing medicine is to be referred back to the committee for further study and report at the San Francisco meeting next June. The report would compel the Council on Medical Education and Hospitals to withdraw approval for intern training of hospitals found engaging in the practice of medicine. Fear was expressed that such action might be interpreted as restraint of trade.

CHANGE IN PUBLICATIONS PERSONNEL

Official announcement was made of Dr. Morris Fishbein's retirement as editor of *The Journal* and Dr. Austin Smith, former secretary of the Council on Pharmacy and Chemistry, as his successor. Dr. Robert T. Stormont, medical director of the Food and Drug Administration at Washington, succeeds Doctor Smith.

Hygiea, the health magazine, will be known as *Today's Health* after February or March. Dr. W. W. Bauer, director of the Bureau of Health Education, is its new editor, succeeding Doctor Fishbein.

DP RESOLUTION DEFERRED UNTIL JUNE

A resolution calling for appointment of a committee to study the displaced doctor problem with a view of finding ways and means for them to practice medicine in the United States was introduced on the final day of the House and held over until the June session. It would encourage liberalization of medical practice regulations.

FATE OF INDIANA'S THREE RESOLUTIONS

Delegates from Indiana presented three resolutions, none of which was adopted. One resolution called for three years in general practice as a requirement for a specialty. The Reference Committee on Medical Education and Hospitals expressed sympathy with the objective, but pointed out that medical schools could solve the problem by educating young physicians to the value of a period in general practice before they take up a specialty.

Another resolution recommended that insurance companies be asked to print on their policies this legend: "This Policy Guarantees to the Holder His Free Choice of Physician or Surgeon." A special reference committee on Health Insurance Plans recommends this be a matter left to the states, and the delegates so voted.

The third resolution recommending that the A.M.A. take the leadership in requesting draft legislation if the military services could not get sufficient doctors through enlistments was noted. A similar resolution was acted upon last June.

CONTINUE BLOOD BANK SURVEY

Action upon the blood bank problem was delayed until next June so that a survey now in progress may be completed. General Marshall, chairman of the American Red Cross, is concerned with the money, said to be about 10 percent of contributions, being spent by the Red Cross on its blood bank program. The A.M.A. Liaison Committee on Blood Banks said, in part: "A coordinated program on the national level, with complete integration of private and hospital blood banks with the Regional Red Cross Blood Centers on the local level, and an informed and trained medical profession, will be able to meet any emergency (local or national) which may arise."

At present, the report stated, "there is little uniformity or standardization of equipment used for the procurement and dispensing of blood, a fact which might conceivably result in the loss of countless lives among the civilian population in the event of emergency, local or national."

The committee reaffirmed its opinion that the "Red Cross is the logical agency to assume responsibility for this phase of the national blood program."

OPPOSE MEDICAL SCHOOL AID BILL

The delegates followed a recommendation of the trustees and Council on Medical Education and Hospitals that a bill passed by the U. S. Senate and still pending before the House of Representatives for granting federal funds to medical schools be opposed on the grounds it "does not guarantee the freedom of medical schools and contains other undesirable features."

CONCERNED ABOUT CIVILIAN DEFENSE

The delegates also adopted a resolution requesting the National Security Resources Board "to inform the A.M.A. as to the present state of preparation for civil defense in the event of a national emergency, particularly as it relates to medical and health problems that might arise through use of special weapons of warfare, atomic, biologic and chemical."

The Council on National Emergency Medical Service, the resolution charged, "has been unable to discern a clear picture of the federal government's plans for meeting the health and medical care problems of civil defense."

The Council further requested data on "the development of a common method of examination, classification and assignment of manpower according to the physical requirements of the armed forces as recommended by the Department of Defense."

FREE HEALTH SERVICES OPPOSED

The School Health Bill (S. B. 1411) came in for criticism because Section C permits schools to supply health services for all children.

NEW REFERENCE COMMITTEE APPROVED

Upon request of the speaker of the House, a new standing Reference Committee on Insurance Plans and Medical Service was created by amending the Constitution and By-Laws.

WILL STUDY VETERAN HOSPITAL SERVICES

Upon resolution from Tennessee, asking a change in the form of medical and hospital benefits to which veterans with non-service-connected disabilities are entitled, a special committee of five delegates was authorized to make a study of the subject, establish a policy relative to the problem, and report in June.

PUBLIC HEALTH DOCTORS' SALARIES

Salaries commensurate with duties and responsibilities of public health doctors was advocated. It was pointed out that salaries were not high enough in many instances to procure adequately trained doctors.

WILL STUDY MEDICINE ABROAD

A five-man committee to investigate medical care plans abroad was authorized by the trustees. Dr. Walter E. Martin of Norfolk, Virginia, an internist and a member of the board of trustees, will be the chairman.

GRIEVANCE COMMITTEES RECOMMENDED

State medical associations were urged to appoint grievance committees to adjudicate differences between patients and physicians. Indiana is among several states which already has created such a committee.

NEW SECTION IS APPROVED

A Section on Military Medicine and Surgery, requested at Atlantic City last June, was voted on a temporary basis, upon recommendation of the Council on Scientific Assembly.

ENLARGING WASHINGTON OFFICE

The A.M.A.'s Washington office will be enlarged by the addition of one more man. A recommendation that a committee of seven be named to facilitate its activities and the dissemination of information was approved.

DELEGATES GET ASSIGNMENTS

Two of Indiana's four delegates served on reference committees. Dr. A. S. Giordano of South Bend was a member of the Committee on Amendments to the Constitution and By-Laws, while Dr. William M. Cockrum of Evansville served on the special Committee on Insurance Plans and Medical Service. Active at the meeting was Dr. R. L. Sensenich of South Bend, past president of the A.M.A., who is a member of the Coordinating Committee, which is helping direct the national fight against socialized medicine.

ILLINOIS DOCTOR WINS RECOGNITION

Dr. Andy Hall, 84-year-old Mount Vernon, Illinois, physician was elected "General Practitioner of the Year." He has been in practice for nearly sixty years, and has three sons who are doctors.

The annual A.M.A. meeting will be held in San Francisco June 26-30. The next Clinical Session (interim meeting) is scheduled for Denver, Colorado, November 28-December 1, 1950.

CONFERENCE OF COUNTY SOCIETY OFFICERS

Featuring the sixth annual National Conference of County Medical Society Officers, held the night of December 8, was an address by George N. Craig, of Brazil, Indiana, commander of the National American Legion. Dr. A. M. Mitchell, of Terre Haute, chairman of the conference committee, presided.

"The American Legion is opposed to national health insurance because it would stunt the growth and genius of the medical profession, and because it would add another link to an already long bureaucratic chain," Craig told the conference.

Craig urged greater expansion of health services and said the Legion wanted to "join with and be joined by the doctors of the country in bringing about necessary adjustments.

"One of the primary needs is for additional personnel and facilities in communities where shortages exist," he continued. "We must train more doctors and nurses, and build the hospitals and clinics which are essential to community health."

Senator John L. McClellan of Arkansas, who had just returned from a trip to Europe, was an unscheduled speaker. His tour, he said, had made him more appreciative of America. It was his observation that where governments had become paternalistic, the people had surrendered their liberties.

Indiana physicians registered at Washington were:

Alvey, Charles R., Muncie
Black, Claude S., Warren
Black, Edgar K., Wabash
Challman, William B., Mount Vernon
Cockrum, William, Evansville
Crockett, Franklin S., LaFayette
Denny, James W., Indianapolis
Dugan, Thomas J., Indianapolis
Edwards, Bernard, South Bend
Ellison, Alfred S., South Bend
Filipek, Walter J., South Bend
Frost, John W., Indianapolis
Giordano, Alfred S., South Bend
Grayston, Wallace S., Huntington
Gregoline, A. F., Gary
Hamer, H. G., Indianapolis
Hardy, John J., North Liberty
Hibner, N. A., Monticello
Holman, Jerome E., Sr., Indianapolis
Huber, Carl P., Indianapolis
Jones, C. M., Whiting
McCaskey, C. H., Indianapolis
Mitchell, Albert M., Terre Haute
Owen, John E., Indianapolis
Patrick, Glenn B., Elkhart
Plain, George, South Bend
Ragsdale, H. C., Bedford
Ryan, William J., Columbus
Schutt, J. B., Ligonier
Sensenich, Roscoe L., South Bend
Smith, James S., Muncie
Tomlin, Hugh M., Muncie
Weinberg, B. A., Whiting
Zweig, Elmer S., Fort Wayne

THE RESPONSIBILITIES OF THE DOCTOR AS A CITIZEN*

Rufus B. Robins, M.D.†

CAMDEN, ARKANSAS

TOO OFTEN American citizens, as well as citizen-doctors, find themselves too busy with everyday problems to pause and take stock of potential dangers to the American way of life. Quite often we find ourselves so engrossed in daily problems that we find it difficult to believe, in our awareness that we are doing a good job, that destructive elements might be planning to attack the very foundation of the American institution which you and I are committed to protect. Such an attack, directed at free enterprise in American medicine and designed to subject the health of the nation to political control, is upon us right now. The attack on American medicine embodied in the efforts to enact Compulsory Health Insurance contains an ominous threat to the entire American system.

Compulsory Health Insurance is *certain* to generate more heat—both on and off Capitol Hill—in the next year than ever before. Compulsory Health Insurance is nothing more than socialized medicine disguised thinly by a trick of terminology. Let no one in this nation believe that if medicine is nationalized the march to statism will stop there. Socialization of medicine has been the first step in total socialization of the state wherever the experiment has been undertaken.

We seem to accept freedom as a matter of course. Freedom is not free. It is only preserved by effort and eternal vigilance. Our fathers taught us to be self-reliant. Today the social planners are trying to teach people to rely on their government. We must, as citizens, alert our fellow Americans to the fact that the government cannot furnish "something for nothing." Whatever is given from Washington must be at the people's own expense. The basic struggle in our country today is between those of us who want to retain individual freedom and our enemies, who would subordinate the individual to the dictates of a powerful central government. We fought two wars against totalitarianism in the world and now we are face to face with a similar fight on our own domestic front. The doctors of America are in the front lines of this most critical internal struggle.

So many times I hear doctors, as well as other citizens, say, "What can I do? I am just

*Excerpt from an address before the Indiana Academy of General Practice at the annual session of the Indiana State Medical Association, in Indianapolis, September 28, 1949.

†Member of A.M.A. Coordinating Committee for the Protection of the People's Health.

one individual—just one drop in the bucket." If any one of you has taken that attitude then, I ask you this question: "What would happen if every other individual in America took the same attitude?" We would lose by default, wouldn't we?

I say to you that each one of you, as an individual, is important in this fight. Don't sell yourselves short. The tendency of modern times is to make the individual feel unimportant. The average man feels wholly inadequate to cope with the many complex situations. He asks himself what can one man do anyway, and arrives at the conclusion that others are better fitted than he to take the responsibility, so why concern himself too much about present-day problems. That is taking an inferior attitude—that is taking a defeatist attitude. Gentlemen, most of your limitations are self-imposed. A "do-nothing attitude" is inexcusable. Don't sell yourselves short, because in the coming months you can do a wonderful job for the future of American medicine.

On you and your fellow-physicians in America rests a great responsibility in 1950. In my opinion the 1950 elections may well be the most important nonpresidential vote in our history. It appears now that the "trend toward socialism" will either be augmented or it will be throttled by the results of the 1950 elections.

It behooves you to take a keen interest in political affairs. Democracy functions through politics, as you well know. It is inconsistent of us to criticize actions of politicians, while we ourselves evade political service or interest in political affairs.

Doctors have a tremendous political potential with their patients and friends, but it is seldom used. It is used in my state and we are proud of it. Down home the physicians and dentists take some interest in political affairs and I am happy to tell you that our Governor, Senator John L. McClellan, Senator J. W. Fulbright, and every one of the Congressmen from the state of Arkansas are 100 percent against compulsory health insurance and all of them have so stated, both privately and publicly.

If the doctors of America want to remain free doctors, it is high time that they began to assume their full responsibilities as citizens. One of the most frequent criticisms made of the medical profession in the past has been that many doctors are almost as aloof from the world as are some educators and clergymen. Doctors must take an active part in politics and not feel that they are muddying their togas by so doing. THAT WORD IS SPELLED "TOGAS."

It is going to be a sad commentary on the medical profession if the doctors in Indiana and every other state in the union are not registered and vote in the elections of 1950.

We must frankly discuss this issue of socialism with the candidates in next year's campaign and we must obtain commitments from them. Let's win our battle at the polls rather than wait and fight it out in Washington. We did that in Arkansas—you can do it in Indiana.

THE NEED FOR PHYSICIANS IN OUR LEGISLATURE

W. F. Kelly, M.D.*

INDIANAPOLIS

THE TIME has come when physicians must put aside their prejudices against participating in politics and take a very active part in this line of endeavor.

Contributing money to political party support does not accomplish enough toward winning support for our program.

We find that we must be on the job all the time if we expect to protect the public interests. Recently, in conversation with one of our leading state politicians, he made the statement that if there were two physicians in each house of the legislature we would never have to worry about being able to defeat any adverse legislation.

At present we are facing three very pressing problems: (1) the lowering of the standards of requirements for the practice of the healing art; (2) the starting of state medicine; (3) the continuance of our fight to improve health conditions for the public. There has never been a time when these problems were more urgent.

We have a real fight on our hands in the 1951 state legislature and we need more than financial support. Doctors are needed in our legislative bodies who can command the respect and support of their fellow members. In this way we can accomplish much.

In closing, I should like to urge all doctors who can possibly do so to file for the legislature early and make a strong campaign for election. I am lonely and need some of my own kind with me.

*Member of Indiana State Senate.

Grievance Committee Begins To Function

A Grievance Committee authorized by the House of Delegates at the centennial convention last September for the purpose of giving the public an opportunity to air its complaints against the medical profession is now functioning.

The following announcement was sent to Indiana newspapers by the committee:

"The Indiana State Medical Association has announced the organization of a Grievance Committee, composed of five of its past presidents, to hear complaints against its members. The association's House of Delegates established the committee last autumn, and Dr. C. S. Black of Warren, association president, has just appointed the committee. Dr. Jacob T. Oliphant of Farmersburg, Sullivan county, is chairman. Other members are Dr. Carl H. McCaskey of Indianapolis, Dr. Augustus P. Hauss of New Albany, Dr. Charles N. Combs of Terre Haute and Dr. George R. Daniels of Marion.

"The committee will collect evidence as would a grand jury, and where it believes a physician to be guilty of unethical conduct, the case will be referred to his county medical society or to the Council of the state association for appropriate disciplinary action.

"Only complaints made in writing will be considered by the committee. A copy of the complaint will be forwarded to the physician involved with a request that he contact the patient and try to reach a satisfactory understanding. Later, if necessary, the principals will be invited to appear before the committee and submit evidence.

" 'Establishment of the Grievance Committee is indicative of the medical profession's sincerity in trying to provide the people of Indiana with good medical care at equitable fees,' said Doctor Oliphant. 'Complaints most frequently voiced against doctors are the difficulty of getting medical services in the home, particularly at night, and the wide variation in fees charged for what appears to be equal service.' "

"Doctor Oliphant pointed out that through insistence of the state medical association doctors are now available for emergencies on round-the-clock basis in all Indiana communities through arrangements made by the county medical societies.

"Most county societies have boards of censor or ethics committees to which are referred complaints against local doctors, Doctor Oliphant explained, but the profession thinks a grievance committee at the state level will be more effective.

"The Indiana medical association is among the first in the nation to set up a grievance committee to compose differences between physicians and patients. Doctor Oliphant declared that the medical profession is eager to develop better relations with the public by eliminating the causes that create ill feeling against doctors.

"Complaints may be sent to members of the Grievance Committee or to the Indiana State Medical Association office, 1021 Hume Mansur Building, Indianapolis 4, Indiana."

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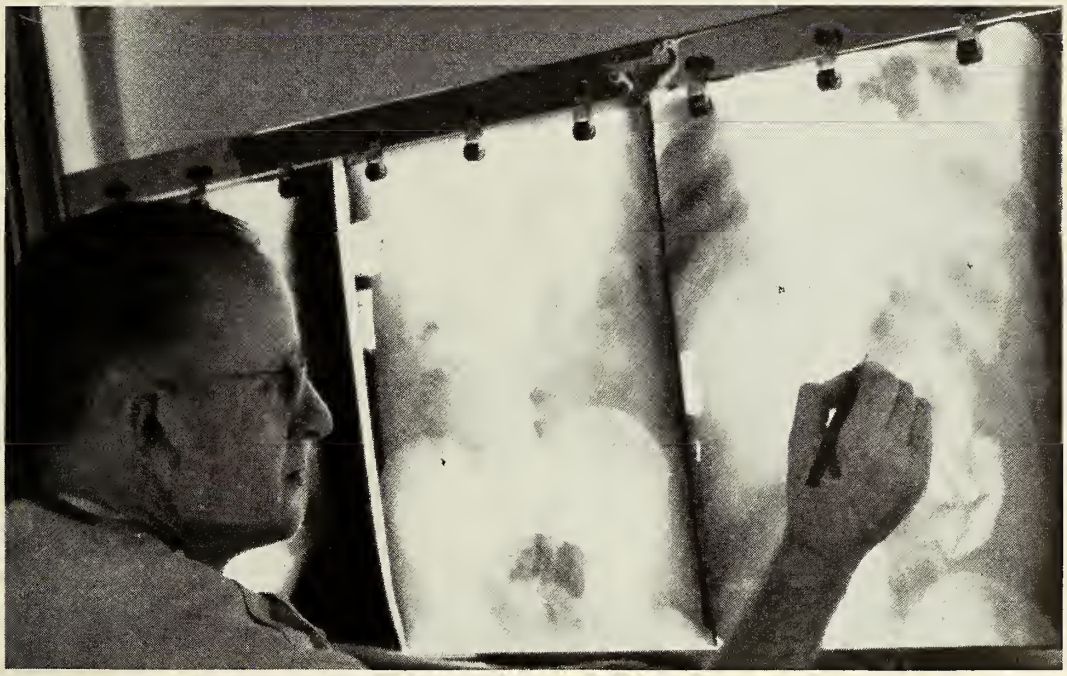

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RESEARCH IN THE SERVICE OF MEDICINE

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

THE DOCTOR'S DILEMMA

It is obvious that the topic of paramount public interest in the discussions of the House of Delegates of the American Medical Association, which convened here yesterday, will be the much-vexed questions of compulsory health insurance and socialized medicine. It would, however, be a great pity if this question were permitted to obscure the scientific program, which promises to be of great importance, especially in the matter of cancer research, yet this seems likely to be the case.

Dr. Elmer L. Henderson, who is soon to take over the presidency of the association, has admitted that Washington was chosen as the site for this meeting largely for the purpose of impressing the Administration with the determination of the doctors to continue their fight against the proposed health program. About a year ago the association voted to spend some millions of dollars upon an "educational campaign"; but thus far the doctors themselves have not proposed any practicable alternative to President Truman's impracticable plan. If they have been able to devise one, it will undoubtedly be disclosed in the course of the meeting.

Meanwhile attacks on the intransigence of the association's attitude have been increasing. An example is the series of two articles by Prof. Milton Mayer, the second of which appears in the current issue of *Harper's Magazine*. Insisting that health insurance is one thing and socialized medicine another, Professor Mayer concludes that if socialized medicine is to be avoided, members of the association must yield a good many more of their present privileges than they have yet shown any disposition to yield. It is time, he thinks, that the doctors realized that their present attitude will not—

> save them from the clamor of millions of people for a new equity in society, for [quite literally] a new lease on life. The medical insurance bills made further progress in Congress each time they were buried under A. M. A. pressure, furthest of all in the last session when no fewer than 17 alternatives to the Truman program went into the hopper. The members of the profession will either accept the fact that the twentieth century is here . . . or lose their freedom fighting for their freebooting. If socialized medicine . . . is ever fastened upon this country, the American Medical Association will call government insurance the American way. But it will be, for the last time, too late—*The Washington (D. C.) Post.*

LESSON FROM NEW ZEALAND

The British Commonwealth country of New Zealand has had a Socialist-Labor government for 14 years. It has introduced nationalization, farm subsidies, state marketing of exports, minimum wages set by government, compulsory unionism, "free" medicine, old-age pensions, and a wide range of other social measures by which the state gives "benefits" to the people.

But on Wednesday the people of New Zealand kicked out their socialist government and voted to return to economic freedom. Why? Because the "benefits" of socialism cost so much that they were impoverishing the country; because the cost of living had risen so high so fast that the people found they were worse off with all their "benefits" than they had been without them; because taxes were so high that the people no longer were able to keep enough of what they earned by their work and enterprise to support themselves.

We have always believed that the best argument against socialism is to try it. Every nation that has tried it from Rome to Germany, from Russia to Britain has ended up by impoverishing the people and destroying their real security. Usually the monopoly state of socialism has turned into the police state of terrorism. New Zealanders were lucky. They were able to change before the powers surrendered to their leaders were so great that they could no longer take them back.

New Zealanders have discovered by trial and by error that freedom and progress must go together, that freedom cannot be divided, that when you surrender economic liberty you will inevitably surrender other liberties as well, and that no government can create prosperity by making a law against poverty.

The United States is today on the verge of embarking on the same experiment New Zealand tried 14 years ago. The Fair Deal proposes the very measures which the people of New Zealand have just rejected.

Let us hope Americans will choose to keep their freedom and save themselves from the planned poverty, the unsupportable taxation and the final dictatorship that socialism has always brought upon every people that tried it.

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News Notes

INDIANAPOLIS OBSTETRIC & GYNECOLOGY SOCIETY ANNUAL MEETING

Speaker: Dr. Richard W. TeLinde, Professor of Gynecology, Johns Hopkins University School of Medicine; Gynecologist-In-Chief, Johns Hopkins Hospital, Baltimore, Maryland.

Subject: "The Diagnosis and Treatment of Early Carcinoma of the Cervix."

Place: Indianapolis Athletic Club.

Time: Wednesday, January 11, 1950. 6:30 p.m. social hour; 7:00 p.m. dinner.

All members of the medical profession are cordially invited. Tickets are available at the office of the secretary, Dr. S. H. Gardiner, 314 Hume Mansur Building, Indianapolis.

BRAYTON CLINICS SCHEDULED

The Alembert Winthrop Brayton Skin and Cancer Foundation has scheduled special clinics for January through May, 1950. These will be held at Indianapolis General Hospital. On January 12 Dr. James R. Driver, from the department of dermato-syphilology at Western Reserve Medical School at Cleveland, will conduct the clinic. There will be a discussion of radium implantations, and a viewing and discussion of cases from 8:30 a.m. until 12:00 noon, when a luncheon will be served for the staff and guests.

On February 9 Dr. James R. Webster, from the department of dermato-syphilology at Northwestern University Medical School in Chicago, will be the conductor. He will discuss differential diagnosis of eruptions of the feet. This will also be followed by a viewing and discussion of cases. This program begins at 8:30 a.m., and continues until 12:00 noon, when luncheon will be served.

INDIANA COUNCIL FOR CHILDREN

Governor Schricker recently appointed an Indiana Council for Children, to study and integrate services for children throughout the state, and to act as Indiana's delegates to the 1950 White House Conference. The following physicians are members of the council: **Dr. Robert E. Jewett, Dr. L. T. Meiks** and **Dr. William D. Smith,** all of Indianapolis; and **Dr. E. R. Carlo,** Fort Wayne. Ex-officio members include **Dr. John Van Nuys** and **Dr. L. E. Burney,** both of Indianapolis.

SECOND ANNUAL ASSEMBLY OF AMERICAN ACADEMY OF GENERAL PRACTICE TO BE HELD IN ST. LOUIS IN FEBRUARY

The American Academy of General Practice will hold its second annual assembly in St. Louis, February 20-23, 1950. The scientific and educational program is designed to stimulate the interest of the general practitioner. Those who attended the first assembly, in Cincinnati last March, know how successful it was. This second assembly is to be even greater in scope. All general practitioners in Indiana are urged to attend. For further information, write the secretary of the Indiana Academy, 447 East Maple Road, Indianapolis, or the American Academy, 406 East 34th Street, Kansas City 2, Missouri.

SIXTH ANNUAL CONGRESS AMERICAN COLLEGE OF ALLERGISTS

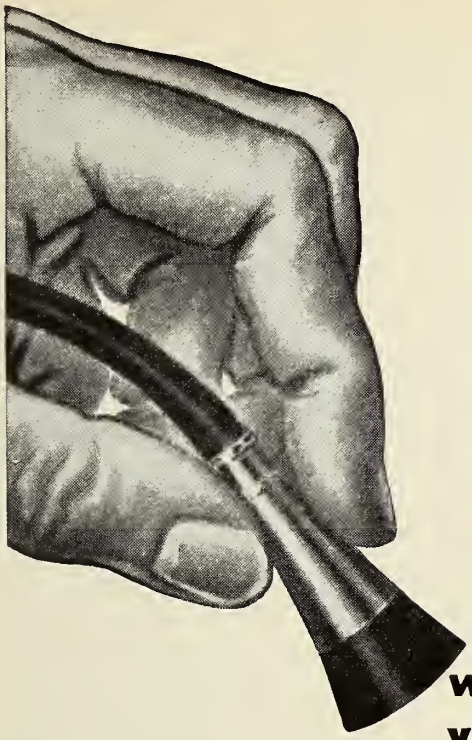
The sixth annual congress of the American College of Allergists will be held at the New Hotel Jefferson, in St. Louis, January 15-18, 1950. There will be forty-two well-known physicians and allergists on the program.

EXAMINATIONS FOR APPOINTMENT IN NAVY MEDICAL CORPS TO BE HELD JANUARY 16-20, 1950, AT NAVAL HOSPITALS

Professional examinations for the selection of candidates for appointment to the grade of lieutenant (junior grade) in the Medical Corps of the Navy will be conducted at all naval hospitals in continental United States during the period January 16-20, 1950. Midwestern candidates will be examined at the U.S. Naval Hospital, Great Lakes, Illinois.

Graduates of approved medical schools in the United States or Canada who have completed intern training in accredited hospitals or who will complete such training within four months of the date of the examination, and who are physically and otherwise qualified, may be examined for appointment as lieutenant (junior grade) in the Navy Medical Corps. Candidates must be less than 32 years of age at the time of appointment.

Detailed information concerning the form and procedure of application may be obtained from the Bureau of Medicine and Surgery, Navy Department, Washington 25, D.C. (Attn: Code-3424) or Ninth Naval District, offices of naval officer procurement at 844 N. Rush St., Chicago.



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Public Health Service grants of $907,212, to aid laboratory and clinical research in nonfederal institutions were announced recently by the Federal Security Administrator. The awards were made by the National Cancer Institute to hospitals and universities in 21 states and the District of Columbia, following recommendation by the National Advisory Cancer Council and approval by Surgeon General Leonard A. Scheele. Indiana University at Bloomington has received a grant in the amount of $1,998, for the study of chemotherapy and carcinogens of the carbazole series.

Public Health Service grants for medical and allied research projects were announced recently by the Federal Security Administrator. The grants were made by the National Institutes of Health, following recommendation by the National Advisory Health Council and approval by the Surgeon General of the Public Health Service. A list of the new grants in Indiana are:

Indiana State Board of Health, $7,875, for research in the incidence and diagnosis of brucellosis in Indiana and isolation techniques for Brucella organisms.

Indiana University, Bloomington, $7,500, for internal structure of protein molecules in the native and the denatured state.

Indiana University, Bloomington, $3,132, for a study of the growth requirements of Toxoplasma gondi (R.H. strain).

Examinations for Scientists (Bacteriologist) in the Regular Commissioned Corps of the U. S. Public Health Service will be held March 20-22, 1950, in various cities throughout the country. Completed applications must be in the Washington Office by February 20, 1950. For application forms and additional information write to: Surgeon General, U. S. Public Health Service, Federal Security Agency, Washington 25, D.C., Attention: Division of Commissioned Officers.

Plans for greater Federal Government assistance in the field of industrial health are now being formed in line with recommendations of the newly-appointed Advisory Committee to the Public Health Service on Industrial Hygiene, which met recently in Washington, D.C., it was announced recently by Acting Federal Security Administrator John L. Thurston.

Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, reported that a 10-member committee discussed cooperative working relationships as well as technical problems and urged that the Public Health Service further integrate its efforts with the U. S. Department of Labor to insure the health and well-being of workers in industry. Among the problems considered by the group was the need for further study of air pollution.

More than 34½ million persons are enrolled in the 90 Blue Cross Plans in the United States and Canada according to Dr. Paul R. Hawley, chief executive officer of the Blue Cross Commission, Chicago. Actual enrollment on June 30, 1949, was 34,554,012.

On the basis of the latest census figures, 22 percent of the total United States population and 20 percent of the Canadian people are protected by Blue Cross. The five Canadian Plans, serving eight of the Dominion's Provinces, had 2,406,962 members enrolled on June 30.

Leading all plans in growth was Associated Hospital Service of New York, New York City, with a gain of 152,440 new members during the second quarter, followed by Michigan Hospital Service, Detroit, with 69,311 and Hospital Service Plan of New Jersey, Newark, with 47,889.

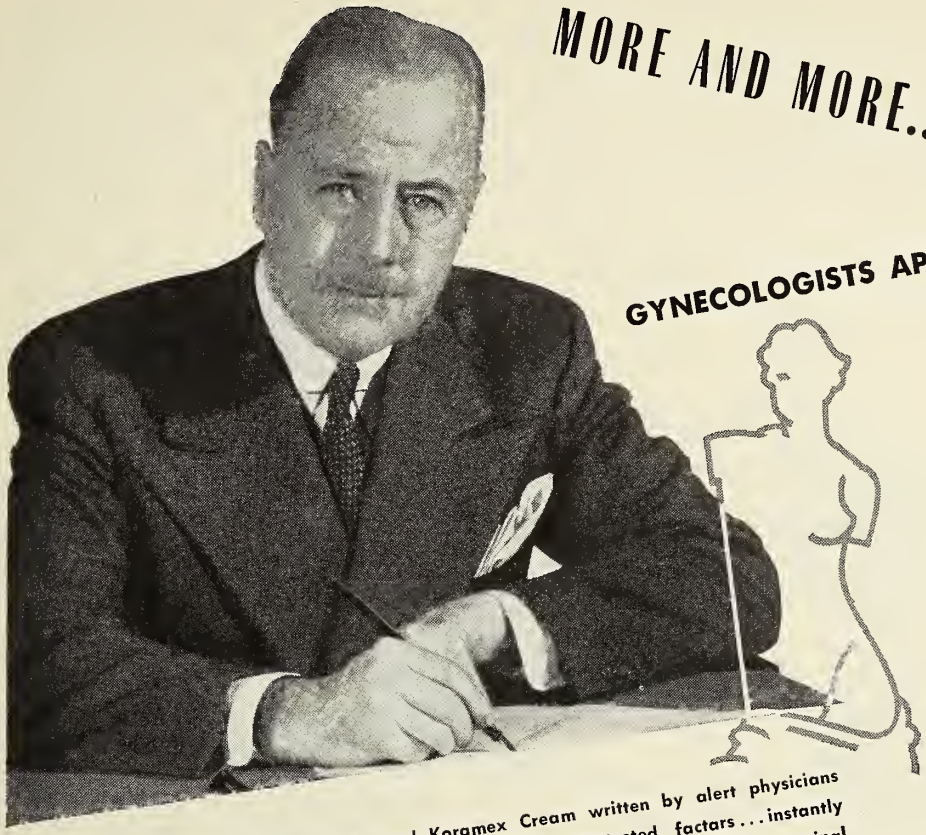
Hospital Service Corp. of Rhode Island, Providence, continued to lead all plans in percentage of state population covered with 71 percent of the state enrolled. In second place was Group Hospital Service, Inc., Wilmington, Del., with 56 percent of the state enrolled.

Largest percentage increase in enrollment for the second quarter of 1949 was reported by Arkansas Medical and Hospital Service, Inc., Little Rock, which increased membership by 382.55 percent. The Arkansas Plan, which received official approval as a Blue Cross Plan in 1948, began its enrollment of members in Blue Cross in January, 1949.

To provide for more complete protection against the costs of unexpected illness a prepaid surgical care program, known as Kentucky Physicians Mutual, Inc., has been organized by the Kentucky State Medical Association. Dr. Oscar O. Miller, Louisville, one of the leading figures in the organization of the program, has been chosen president of the new plan and D. Lane Tynes, executive director, Community Hospital Service, Inc., Louisville, has been named to direct the new Blue Shield Plan.

Indiana University employees and members of their families, numbering over 8,000 persons at Bloomington, Indianapolis and elsewhere in the state, have secured full membership in the Blue Cross-Blue Shield hospital and surgical plans.

The Marion County Society for Crippled Children and Adults has announced that Mr. Roy E. Patton assumed duties as executive director of the society on December 1. Mr. Patton received an A.B. degree from Northwestern State College, and a Master's degree from the University of Oklahoma. He has been connected with the Vocational Rehabilitation Division of the state of Oklahoma for the past eight years.



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Dr. Nicholas C. Johns, who has been practicing in Argos, has moved to South Bend, and is located at 1329 North St. Joseph Street there.

Dr. John Eric Dalton, of Indianapolis, was recently elected to active nonresident membership in the Chicago Dermatological Society.

Dr. Arthur P. Echternacht, of Crawfordsville, has accepted a position as radiologist in St. Joseph Mercy Hospital in Fort Dodge, Iowa.

Dr. Henry W. Greist, of Monticello, has retired from active practice and has gone to Santa Monica, California, to spend the winter. His address there is Apartment 510, Hotel Miramar.

Announcement was made recently of the appointment of **Dr. Russell S. Henry**, of Indianapolis, to the board of managers of the Marion County Tuberculosis Hospital at Sunnyside.

Dr. Iva M. Miller has opened an office for the practice of medicine at 420 East Twenty-third Street, in Indianapolis. She has recently been at the Richmond State Hospital.

Dr. E. G. Moore has opened an office in Gary for the practice of medicine and surgery. He is a graduate of the Meharry Medical College, and received additional training at the Harlem Hospital in New York. He also served a preceptorship in Cleveland.

Dr. John Larson, superintendent of the Logansport State Hospital, has announced the appointment of two new staff members: **Dr. George W. Morrow**, assistant superintendent, and **Dr. Max Pfuetze**, resident physician and surgeon. Doctor Morrow has been superintendent of the Kankakee, Illinois, state hospital for the past eleven years, and Doctor Pfuetze has been staff physician at the Kearn General Hospital in Bakersfield, California.

Dr. John J. Reed, formerly of Chicago, has opened an office in Hobart for the practice of medicine and surgery. He is a 1948 graduate of the Loyola University School of Medicine, following which he interned at Cook County Hospital in Chicago. He is a veteran of World War II, having served for three years in the navy in the Pacific theater.

At the recent meeting of the **Association of American Physicians and Surgeons**, which was held in Detroit, the following Indiana physicians were appointed to committees to serve until October, 1950: Legislative, **William M. Cockrum**, Evansville; Medical Economics, **Virgil McCarty**, Princeton, and **James L. Doenges**, Anderson; Finance Committee For Special Activities, **Arthur A. Rang**, Washington.

The Public Health Service of the Federal Security Agency to date has granted $891,487 to state and interstate agencies, and to the territories, for studies of water pollution resulting from industrial wastes. The state of Indiana will receive $18,321.

The Council on Industrial Health of the A.M.A. will hold its Tenth Annual Congress on Industrial Health at the Roosevelt Hotel in New York City, February 20 and 21.

MERGER OF ARMED FORCES MEDICAL JOURNALS

Consolidation of the professional medical publications of the armed forces into a "U.S. Armed Forces Medical Journal" and its supplement, the "Medical Technicians Bulletin of the U.S. Armed Forces," was announced recently by Secretary of Defense Louis Johnson. The new medical journal, scheduled for monthly publication beginning with the January 1950 issue, will replace the "Bulletin of the U.S. Army Medical Department" and the "U.S. Naval Medical Bulletin." The Air Force, whose separate medical department was created last July, has not had a similar journal. Each of the three services will be represented on the editorial staff, with the Navy member serving as the first editor-in-chief.

GENERAL BLISS ANNOUNCES ARMY INTERNSHIP APPOINTMENTS

One hundred and ninety senior medical students have been appointed to Army internships beginning next July 1, Major General R. W. Bliss, the Army Surgeon General, has announced.

They represent the Army's selections out of the 1014 candidates who applied for both Army and Air Force internships.

Sixty-four of the 71 approved medical schools in the country are represented in the group of selectees, 96 percent of whom are former service men. Sixty-one of the successful candidates are former noncommissioned technicians and specialists. One hundred and one of them are former Army commissioned personnel, including three former lieutenant colonels, 20 majors, 35 captains, 35 first lieutenants, and eight second lieutenants.

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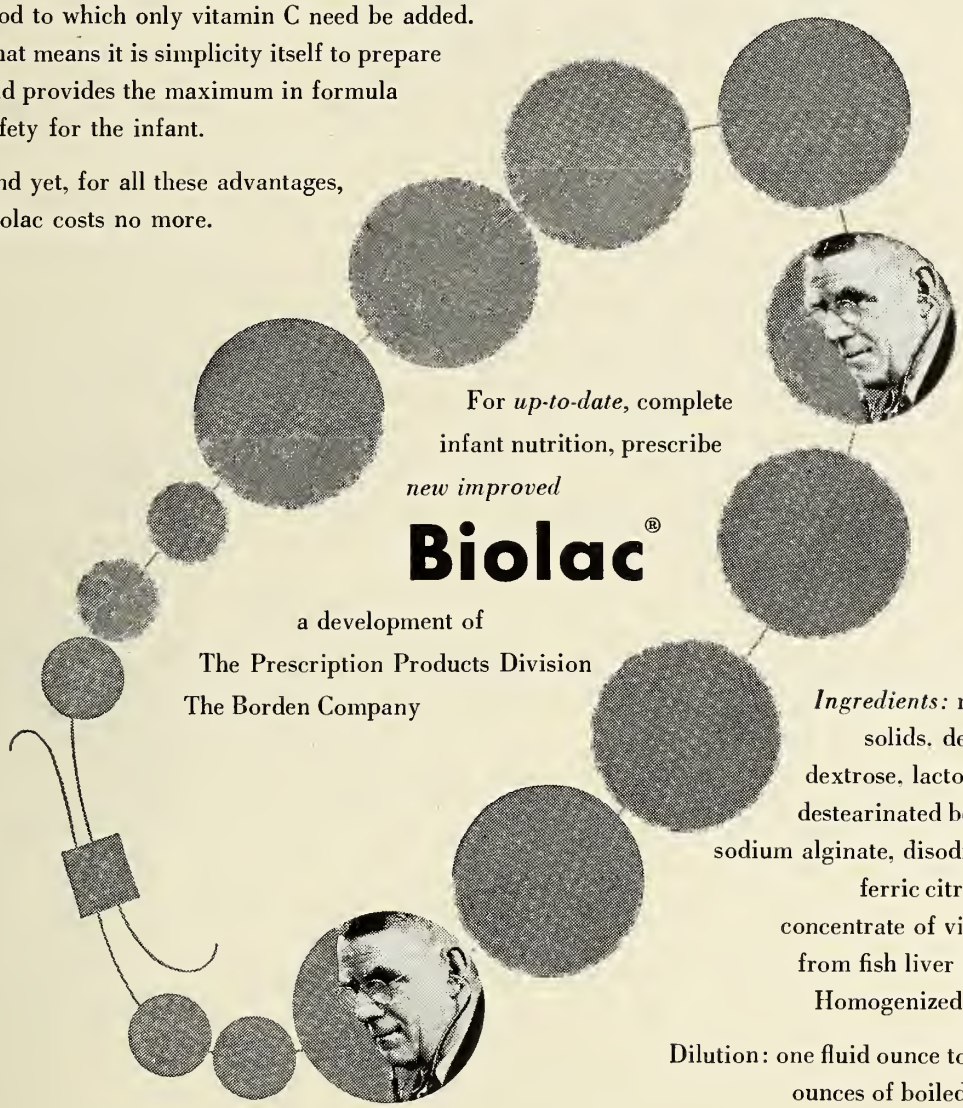

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Indiana University News Notes

Further expansion of the full-time staff of the Indiana University School of Medicine on the Medical Center campus at Indianapolis and the University campus at Bloomington, to meet an increased student enrollment and a growing research program, has been announced by Dean John D. VanNuys. Recent appointments include:

Dr. Herbert S. Gaskill as Professor of Psychiatry; Dr. Edward W. Shrigley as Associate Professor of Microbiology; Dr. Philip F. D. Seitz as Assistant Professor of Psychiatry and director of psychiatric research, all on the Indianapolis campus; and at Bloomington, Dr. Lawrence O. Morgan as Professor of Anatomy; Dr. Raymond G. Murray as Associate Professor of Anatomy; Dr. Richard C. Webster, Assistant Professor of Anatomy; Dr. Robert L. Moss, Instructor in Anatomy; and Dr. Aaron J. Ladman, teaching fellow in Anatomy.

Drs. Gaskill and Seitz were formerly on the staff of the University of Pennsylvania. During World War II Doctor Gaskill was chief of neuropsychiatry with the 20th General Hospital and later was assigned to the Surgeon General's office as an assistant to General W. C. Menninger. Doctor Seitz was chief of neuropsychiatry with the 280th General Hospital and chief of medicine with the 319th station hospital during World War II. Doctor Shrigley was formerly Assistant Professor of Bacteriology at Yale University and is continuing investigative work at the Medical Center which was initiated at Yale.

Doctor Morgan was previously on the staff of the University of Cincinnati and Doctor Ladman also came to the Indiana University School of Medicine from the University of Cincinnati. Doctor Murray has previously been on the staff of Tufts College Medical School and Northwestern University; Doctor Webster came from the University of Kansas and Doctor Moss was on the staff of Jefferson Hospital in Philadelphia.

The presence of outstanding guest speakers on seminar programs at the Indiana University School of Medicine will continue during the coming year. with Dr. A. C. Ivy, vice-president of the University of Illinois, to discuss "Therapeutic Differentiation in the Diagnosis of Jaundice," on January 13 as a guest of the Billings V.A. Hospital staff.

Two members of the Indiana University School of Medicine staff presented papers on research activities before the Ohio Valley Section of the Society of Experimental Biology and Medicine meeting at the University of Louisville, November 12.

Dr. E. W. Shrigley, Associate Professor of Microbiology, presented a preliminary report on the effect of x-ray radiation upon the Rous chicken sarcoma virus, an investigation started in cooperation with Mr. Frederick Vultee, while a member of the staff at Yale University Medical School.

Dr. Versa V. Cole, Associate Professor of Pharmacology; Dr. H. R. Hulpieu, Professor of Pharmacology, and Dr. Samuel Hopper, Associate Professor of Public Health, joined in a report on surface active agents in relation to barbiturates. The report covered eleven of the surface action agents and three barbiturates.

Nearly three hundred members of the American Society for Pharmacology and Experimental Therapeutics, Inc., attended the society's first fall meeting on the campus of the Indiana University Medical Center, November 17-19. In resolutions adopted during a business session the visitors praised the arrangements for the session and the hospitality of the School of Medicine and Medical Center.

One hundred and twenty scientific papers were presented, reporting laboratory and clinical studies of various drugs and two symposiums were held, one on antihistamines and the other on antibiotics. Twelve members and guests attended from outside the United States, including Mexico, Canada, England, Germany, Italy, India and Turkey.

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**Reprints on Request:
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32,241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

Deaths

William Ruston Davidson, M.D., of Evansville, president of the Indiana State Medical Association in 1922, died on October 29, after a long illness. He was seventy-four years of age. Doctor Davidson had served on many association committees, from 1908 through 1946. He was councilor of the First District from 1904 to 1917 and from 1924 to 1928, and was chairman of the Council from 1913 to 1916 and from 1925 to 1928. He was a delegate to the A.M.A. from 1911 to 1913. He was a member of the State Board of Medical Registration and Examination from 1921 to 1937, serving as its secretary from 1922 to 1937. Doctor Davidson graduated from Rush Medical College in 1899, and had practiced continuously in Evansville for fifty years, with the exception of the time he served in World War I. He was a diplomate of the American Board of Surgery, and was a member of the Vanderburgh County Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.

Jack Horton, M.D., of Indianapolis, died on October 20, at the age of 29. He was a graduate of Indiana University School of Medicine in 1944, and had served as flight surgeon with the Ninth Air Force during World War II.

Charles V. Kraft, M.D., formerly of New Albany, died in New Orleans on November 14, at the age of 78. He was a graduate of the Kentucky School of Medicine, in Louisville, in 1897, and had practiced in New Albany, before moving to New Orleans, where he retired from the practice of medicine.

Charles Leslie Aker, M.D., of Greencastle, died on December 2, at the age of fifty-six. He was a graduate of Indiana University School of Medicine in 1923, and had practiced in Mooresville before going to Greencastle, where he had practiced for ten years. Doctor Aker was a member of the Putnam County Medical Society, the Indiana State Medical Association and the American Medical Association.

Herbert Leigh Buckles, M.D., of Hartford City, died on November 24, after a long illness. He was sixty-five years of age. Doctor Buckles graduated from the Ohio State University College of Medicine, Columbus, in 1914. He was a veteran of World War I.

Ira M. Sanders, M.D., of Greensburg, died on December 9, at the age of seventy-nine. He graduated from the Medical College of Indiana, in Indianapolis, in 1896, and had practiced in Greensburg since that time. Doctor Sanders was an honorary member of the Decatur County Medical Society and the Indiana State Medical Association, and was a fellow of the American Medical Association.

Roscoe P. Blood M.D., of Hebron, died on December 2, after a long illness. He was sixty-nine years of age. A graduate of Northwestern University Medical School, in Chicago, in 1906, Doctor Blood practiced in Chicago for four years, before going to Porter County thirty-nine years ago. He had retired from practice recently.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

COMMITTEE ON PUBLICITY

November 11, 1949

Present: Marlow W. Manion, M.D., chairman; Homer G. Hamer, M.D.; James O. Ritchey, M.D.; Frank B. Ramsey, M.D. guest; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of December 12, 1949—"Tularemia"
Week of January 2, 1950—"Hemorrhage"
Week of January 9, 1950—"Shock"

The secretary reported the discussion with the WFBM television station in which they expressed a willingness to use health films from the state association. The committee decided to preview several suggested films at the next meeting.

The committee decided to complete the mailing of LOOK magazine reprints to all licensed M.D.'s, using the list from the Board of Medical Registration and Examination's office.

It was agreed to request a budget for the year 1950 of $2,500.00.

LOCAL SOCIETY REPORTS

LOCAL SOCIETY OFFICERS

CLINTON COUNTY MEDICAL SOCIETY
President, George K. Hammersley, Frankfort,
Vice-President, I. E. Michael, Frankfort,
Secretary-Treasurer, C. D. Holmes, Frankfort.

DE KALB COUNTY MEDICAL SOCIETY
President, R. Perry Reynolds, Garrett,
Vice-President, Max Wills, Auburn,
Secretary-Treasurer, Charles I. Weirich, Butler.

HENDRICKS COUNTY MEDICAL SOCIETY
President, Malcolm Scamahorn, Pittsboro,
Vice-President, O. T. Scamahorn, Pittsboro,
Secretary-Treasurer, Ernest H. Price, Danville.

HOWARD COUNTY MEDICAL SOCIETY
President, J. D. Boughman, Kokomo,
Vice-President, Garvey B. Bowers, Kokomo,
Secretary-Treasurer, E. C. Murray, Kokomo.

INDIANAPOLIS (Marion County) MEDICAL SOCIETY
President, James W. Denny, Indianapolis,
President-elect, Earl W. Mericle, Indianapolis,
Vice-President, Edwin W. Dyar, Indianapolis,
Secretary-Treasurer, Donald E. Wood, Indianapolis.

OWEN-MONROE COUNTY MEDICAL SOCIETY
President, Clarence Marchant, Bloomington,
Secretary, Harry D. Schell, Bloomington,
Treasurer, Naomi L. Dalton, Bloomington.

PERRY COUNTY MEDICAL SOCIETY
President, Earl R. Snyder, Troy,
Vice-President, Fred C. Glenn, Tell City,
Secretary-Treasurer, David A. Dukes, Tell City.

Boone County Medical Society members met at Witham Memorial Hospital, in Lebanon, on November 1. Seventeen members were present. Dr. J. William Wright, Jr., of Indianapolis, spoke on "Anti-histaminics."

Cass County Medical Society members met at the Memorial Hospital in Logansport on November 17. Dr. Arthur B. Richter, of Indianapolis, spoke on "Some Newer Developments in the Treatment of Heart Disease."

Clinton County Medical Society members held a meeting at the Clinton County Hospital in Frankfort, on November 8. Fourteen members were present. The speaker for the evening was Mr. Rodney W. Leonard, architect, who discussed plans for the new hospital wing.

DeKalb County Medical Society members held a meeting at the Auburn Hotel, in Auburn, on November 30. This was a business meeting, during which a resolution against socialized medicine was approved, and officers for 1950 were elected.

Greene County Medical Society members held a business meeting at the Freeman Greene County Hospital, in Linton, on November 17. Sixteen members were present.

Hendricks County Medical Society members met in Avon, on November 16. Ten members were present to hear Dr. W. Donald Close, of Indianapolis, discuss "The Function of the American Heart Association in Indiana."

Howard County Medical Society members held a business meeting in Kokomo on November 4, for election of officers. Twenty members were present.

LaPorte County Medical Society members held a meeting at the U. S. Slicing Machine Company, in LaPorte, on November 17, to discuss methods of improving industrial health and safety. There were 101 members and industrialists present. Mr. M. M. McClure, of the Inland Steel Company, spoke on "Industrial Health and Safety."

Lawrence County Medical Society members held a meeting at Dunn Memorial Hospital, in Bedford, on November 2. Sixteen members were present. The society unanimously endorsed a resolution opposing socialized medicine.

Montgomery County Medical Society members met at Culver Hospital in Crawsfordsville on October 20. This was a business meeting, and twenty-five members were present.

Owen-Monroe County Medical Society members elected officers for 1950 at their meeting on November 25, and Dr. E. W. Dyar, of Indianapolis, gave an illustrated lecture on "External Diseases of the Eye."

Perry County Medical Society members met at Cannelton on December 6. Miss Louella Sweeney discussed the Perry County Welfare Health Program. Ten members were present.

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HEPATIC COMPONENTS IN VARIOUS PHYSIOLOGIC PROCESSES*

FRANK C. MANN, M.D.

ROCHESTER, MINNESOTA

The Author:

Doctor Mann was born in Indiana. He received from Indiana University the following degrees: B.A. in 1911; M.D. in 1913; M.A. in 1914, LL.D. in 1938. He received the degree of D.Sc. in 1937 from Georgetown College. At present he is professor of experimental medicine at the Mayo Foundation, University of Minnesota.

IT IS usual to consider the function of an organ or tissue on the basis of some specific and intrinsically predominant activity, as for example the heart as a pump, the muscles as a mechanism for movement, the mammary glands as a factory for making a specific food, and so forth. However, a large number of the physiologic processes essential for maintenance of life in the higher organisms are not completed wholly by or within one organ or tissue. There are many areas of cooperative interdependence in activities between various organs and tissues throughout the body. The liver has many such components of interdependent activities and it is concerning some of these that I shall speak. I shall first emphasize the widespread distribution and importance of the physiologic processes in which the liver is a component and then consider representative examples of these processes and the results of some recent investigations on them.

Many examples could be cited which would emphasize the widespread distribution of hepatic components in physiologic process. A significant substantiation of this fact is indicated by the arrangement of the subject material dealing with the functions of the liver in the current textbooks on physiology. In these books most of the pages indexed under organs such as the kidney and the heart are for the most part consecutive; those found under the heading "liver" are distributed throughout the book, being located in many places and under diverse headings. Many textbooks of physiology do not have a chapter devoted to the liver and in the book which includes such a chapter, it deals almost exclusively with the secretion of bile and occasionally, in addition, it contains a short abstract on the major functions of the organ. Thus the organization of the books on physiology indicates clearly not only that many of the known functions of the liver are but part, however important, of physiologic processes involving other organs and tissues of the body, but that the number

* Read at the centennial meeting of the Indiana State Medical Association, at Indianapolis, September 27, 1949.

of processes in which the liver is involved is large.

This ubiquity of physiologic activities of the liver is of great importance and must be recognized in studies on the functions of the organ in the healthy organism. It is probably of equal importance in studies on the diseased organism. Understanding of the hepatic phase of a physiologic process often depends on exact knowledge of the anhepatic phase. In some instances the results of studies on the latter have given the first indication that an hepatic phase existed.

The hepatic components of interdependent physiologic activities are of considerable significance in the more or less visionary field between knowledge of hepatic activities and the application of such knowledge to the patient. The history of the many methods that have been used to quantitate liver function indicates the struggle that has occurred in this field. Probably more attempts have been made to develop tests of function of the liver than have been made for any other organ of the body. Yet few such tests have had a long survival or had a wide acceptance. There are many causes for this disappointing result. Foremost among these causes must stand the fact that few of the physiologic processes requiring hepatic activities are without an extrahepatic phase.

Structure and function of an organ or tissue are so often mutually interdependent that a discussion concerning one necessitates a consideration of the other. This statement is particularly applicable to the liver. There are several anatomic arrangements located both within and without the liver which are indicative of the protean aspects of its activity. Only three of these will be mentioned, the cellular constituents of the organ, the hepatic circulation, and the lymphatic system.

CELLULAR COMPONENTS

In addition to the cells of the tissues which are common to most organs, such as the cells of the vascular system, the supporting tissue and the ducts, the liver is composed of two types of cells, the hepatic and stellate cells, which differ anatomically and physiologically from each other.

The stellate cells form a more or less complete lining of the sinusoids of the liver. There is some evidence that everything that enters the hepatic cells from the blood must first pass through the stellate cells. Although these cells are termed "stellate" because of their shape, as noted in the usual preparation of liver tissue, they actually may assume many shapes. They belong to the reticuloendothelial system and have the ability to remove formed particles from the blood stream. Their capacity in this respect is great and they engorge themselves with amazing rapidity. Their span of life is probably longer than that of many of the other cells of the body because stellate cells which contained special substances injected many months previously have been noted. It has not been proved that the activity of the stellate cells differs in any respect from that of the reticuloendothelial cells located in other tissues of the body, but owing to their intimate contact with the portal blood it would not be surprising to learn that they did possess specialized functions not found in other cells of the reticuloendothelial system.

The main cellular constituents of the liver are the hepatic cells. They are located normally in the trabeculae of the liver which extend from the central vein to the periphery of the lobule in a more or less diffuse fashion. The hepatic cells, on cursory examination, appear exactly alike, but careful cytologic examination discloses that their intracellular structure is different and may change rapidly, depending on alteration due to differences in specific cellular activities. The intracellular activities are affected by many factors, such as character and amount of food ingested and alterations in bodily activity.

The results of studies on the cellular constituents of the liver indicate that liver tissue is subjected to extremely rapid changes in rate of, character of, and capacity for functional activity. These essential physiologic characteristics of the liver are of importance in the problem of quantitation of liver function.

HEPATIC CIRCULATION

The circulation of the liver is one of the most fascinating features of the organ and because of its importance has fully justified the numerous investigations which have been made on it. The liver is supplied with a large amount of blood which reaches it from two sources. It receives arterial blood in a manner similar to that of other organs of the body, except that the amount of blood reaching the hepatic tissue is smaller in relation to the mass of tissue supplied than is the case with most of the other organs. In addition, the blood from the portal vein, which drains almost all the blood from the gastrointestinal tract, pancreas and spleen, passes through the liver before it returns to the heart. The relative amounts of blood that reach the liver from each source vary greatly, and often there is a reciprocal relationship between the flow in the hepatic artery and that in the portal vein so that if the flow increases or decreases in one, it does the opposite in the other.

The significance of certain special features of the hepatic circulation in relation to the body as a whole has been further emphasized by the results of some recent work done in the laboratory of my colleague, Doctor Essex.[1, 2] The blood that passes to the liver through both the portal vein and hepatic artery is eventually returned to the vena cava through the hepatic veins. It has long been recognized that these veins contain a mechanism which retards the return of blood from the liver. In this recent work it was found that the administration of certain substances, such as an extract of Ascaris, was not fatal to a dehepatized dog in a dosage

which was several times greater than the amount that would kill a normal animal.

The results of this investigation indicated an unusual condition in which the lack of an organ protected the body from a fatal dose of a substance. The cause of this occurrence was demonstrated by the use of mass injections into the various vessels of the liver. If mass injections of suitable substances are made and the liver tissue is digested away, the normal circulation of the liver stands out as a beautiful picture. In livers studied by this method, after the injection of Ascaris extract, however, hepatic blood vessels presented a mutilated type of pattern because of the failure of the substance used for the mass injection to enter a large percentage of the smaller hepatic veins and even some of the larger ones. Evidently the extract of Ascaris caused a marked contraction of the muscles in the hepatic veins returning the blood from the liver. This in turn not only produced congestion of the liver but also caused stasis in the entire portal system. Other substances have an action similar to extract of Ascaris and this mechanism may possibly be a factor in anaphylaxis, certain types of shock, and other conditions associated with sudden circulatory collapse.

LYMPHATIC SYSTEM

The intrahepatic lymphatic system has not been definitely delineated. The lymphatic vessels can be traced into the portal spaces but the exact site of their origin is obscure. A plausible explanation considers the sinusoids as being completely lined with reticuloendothelial cells, and the space between these cells and the hepatic cells giving origin to the lymphatics. Our laboratory has this problem under investigation at present.

A generous supply of lymph vessels drains from the liver, and the organ is known to be a major site of lymph formation but not to the same extent as the gastrointestinal tract. My colleagues, Drs. Cain, Grindlay, Bollman and Flock,[3, 4] are making some interesting and valuable studies on hepatic lymph. Doctor Grindlay found a plastic tubing which could be passed directly into the lymphatic trunk and in which the clotting of the lymph was prevented or greatly delayed. He also cannulated the hepatic lymph vessels in the dog, and Mr. Van Hook, a technical assistant of Doctor Bollman, developed a technic for cannulating the hepatic lymph vessels of rats.

Only a few of the results of these studies are pertinent to this discussion. The amount of lymph which may be formed in the regions drained by the thoracic duct and also from the liver is astonishing. For instance, the amount of lymph collected from the thoracic duct of a rat during a three-day period about equals the animal's own body weight. If the rat is given saline solution to drink, however, the amount of lymph formed within twenty-four hours is about equal to the animal's weight. After ingestion of a meal of fat, the typical increase in the fat content of lymph in the thoracic duct occurs but the fat content of the hepatic lymph always remains low and fairly constant even when the fat content of the liver is decreasing. This finding would appear to indicate that fat mobilized from the liver does not leave the organ through the lymph. Another interesting observation made in these studies was that the output of lymph from a cirrhotic liver was many times greater than from a normal organ.

METABOLISM OF BILE

The secretory activity of the liver, that of producing bile, appears to be one of the more inclusive intrahepatic activities of the organ. In respect to its secretory activity the liver is not fundamentally different from other glands of the body which produce external secretions. This may account for the fact that the liver function tests based on the secretory function of the organ have survived so long. Nevertheless there are important extrahepatic physiologic processes relating to the secretory function of the organ. The liver is the sole agency for the excretion of bile pigment but this substance is formed by the reticuloendothelial cells located throughout the body, including the stellate cells of the liver. The liver appears to be the site for both the formation and destruction of the bile salts. The bile salts are an important adjuvant to the process of digestion of fat.

METABOLISM OF FOODS

One of the more important groups of hepatic activities relates to metabolism. In this respect the liver is an efficient processing plant. It not only receives two of the three major foodstuffs, carbohydrates and protein, at their portal of entry into the body immediately after they are absorbed, but also receives numerous substances including the third major food stuff, fat, from the other tissues of the body. All these many and various substances must be processed so that they can be metabolized or stored and returned to the other tissues of the body for utilization. Accordingly, the liver functions as a storage, synthesizing and regulating organ for the supply of food to the body and metabolism of the body. In these respects the hepatic components are of great importance, in one instance indeed vital. Actually, however, they are only a part of physiologic processes involving in one manner or another most of the other tissues of the body.

CARBOHYDRATE

The liver is a storage depot for many substances but the story concerning glycogen, the storage form of carbohydrate, even though it had its beginning more than a century ago, remains as one of the most interesting and important stories about hepatic activity. The liver transforms glucose and

other substances into glycogen which can be retained in the hepatic cells. The amount of glycogen stored in the liver varies within wide limits. It is seldom entirely absent from the hepatic cell and the quantity in the liver may accumulate until it equals 20 percent or more of the hepatic tissue. This variability in glycogen content of the liver depends on many factors, the most important of which are the amount and character of food ingested, the extent of bodily exertion and the species of animal. Also it should be noted that changes in the glycogen content of the liver can occur with great rapidity.

Glycogen also is stored in the muscle in approximately the same total amount as in the liver, but on a percentage basis of the amount of tissue the amount is much greater in the latter. Muscle glycogen is made from the blood glucose and the amount varies, depending mainly on the availability of glucose and muscular activity.

The fate of hepatic and muscle glycogen is different. The hepatic glycogen is utilized to maintain the concentrates of glucose in the blood while the muscle glycogen is converted into lactic acid and thus fulfills its functions in relation to the process of muscle contraction. At least part of the lactic acid formed in the muscle returns to the liver and is formed into liver glycogen.

Many products of digestion are absorbed from the intestine or produced in the body in a form which cannot be used efficiently or at all by the tissue cells. This is true of galactose, fructose, amino acids in part, glycerol, lactic acid and many others. The processes of altering many of such substances from a nonusable form into one that can be utilized by the tissues are performed in the liver.

The tissue cells not only must have a constant supply of food in utilizable form, but the amount of food which reaches them must be regulated to meet their varying needs. Hepatic activity appears to be responsible for the regulation of the more important supplies of food to the tissue of the body and while other tissues also may function in some of these processes their capacity appears to be inadequate to meet the demands of the organism.

A vital function of the liver is the regulation of the concentration of glucose in the blood. The concentration of glucose in the blood is one of the important physiologic constants and is normally maintained constantly within rather narrow limits. When the amount of glucose in the blood is greater than the normal limit, the excess glucose is secreted into the urine; if the concentration of glucose in the blood decreases to a low level, symptoms of hypoglycemia occur. It is a vital function of the liver to maintain the concentration of glucose in the blood within definite limits. Not only is hepatic activity responsible for maintaining the normal value for the blood sugar, but the increases in the concentration of glucose of the blood which follow loss of the pancreas, etherization, development of asphyxia, and injection of epinephrine are also dependent on the liver. While alterations in the rate of utilization of glucose in other tissues of the body are dependent on many factors such as fasting, ingestion of foods predominantly of fat, and certain hormones such as insulin, and these alterations in rate of utilization of glucose can affect the blood sugar irrespective of the liver, the restoration and maintenance of the blood sugar level appear to be a specific function of hepatic tissue. Only hepatic glycogen is used for maintaining the level of blood sugar; the glycogen in the muscle is used by that tissue.

PROTEIN

There is some evidence that hepatic activity is important in controlling the supply of protein to the tissues. This may be accomplished by means of the plasma proteins.

FAT

The mobilization and demobilization of fat in the liver appear to involve rather complex mechanisms. Some of the factors causing a variation of the fat content of the liver have been mentioned previously. There is suggestive but not conclusive evidence that some of these factors may be a part of a mechanism for regulating the amount of utilizable fat to the tissues by means of hepatic activity. The formation of ketone bodies from fat in the liver for oxidation in the other tissues of the body during periods when glucose is not readily available may be one of such mechanisms.

COAGULATION

It has long been known that hepatic activity was involved in some manner in the process of coagulation of the blood. While a complete story of the process of coagulation cannot be written at this time, recent work has disclosed some important physiologic relationships between the liver and the process of coagulation. There is substantial but not conclusive evidence that the formation of fibrinogen and prothrombin, two essential factors for the formation of a normal blood clot, is dependent on hepatic activity. In an investigation conducted on rats which had complete intestinal lymph fistulas, my colleagues, Drs. J. D. Mann, F. D. Mann and J. L. Bollman,[5] noted that clotting of the lymph in the cannulae rarely occurred after the first eighteen hours after establishment of the fistula. Furthermore, they found that animals which had lost all their intestinal lymph for several hours were prone to bleed excessively from minor injuries. On investigation of these observations they found that marked hypoprothrombinemia had developed in animals which had lost all of their intestinal lymph. The administration of vitamin K not only prevented the development of the hypoprothrombinemia but also corrected it after it had developed even though loss of lymph continued. These results, taken in connection with the state-

ments made previously, appear to indicate that both fibrinogen and prothrombin are hepatic in origin, that vitamin K is absorbed wholly by way of the lymphatics, and that both prothrombin and vitamin K have a relatively short life in the body.

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STREPTOMYCIN, AUREOMYCIN, CHLOROMYCETIN AND THEIR APPLICATION IN PEDIATRIC PRACTICE*

MAX D. GARBER, M.D.

ROCHESTER, NEW YORK

The Author:

Doctor Garber is a graduate of Indiana University, having received his M.D. degree in 1934. At present he is instructor in pediatrics at the University of Rochester School of Medicine and Dentistry; assistant pediatrician Strong Memorial and Rochester Municipal Hospital; attending pediatrician Genessee Hospital, Rochester, New York.

THE past five years have seen the strengthening of our therapeutic arsenal by the discovery of new antibiotics which have greatly widened the effective scope of medicine's combat against disease. In 1944 Schatz, Bugie and Waksmann[1] discovered and produced a new antibiotic which they named streptomycin. The second important new antibiotic, "chloromycetin" resulted from the combined work and efforts of Burkholder, who first isolated and demonstrated its antibiotic activity, and Ehrlick[2] and his associates, who further extended studies of the antibiotics activity and prepared the compound in crystalline form. In 1948 Duggar[3] presented a third antibiotic, aureomycin, produced from a new species of actinomycete for which the name "Streptomyces aureofaciens" is being proposed. Still another new substance, polymyxin or aerosporin, was announced in 1947, papers by Benedict and Langlykke,[4] Stansly, Shepherd and White[5] and Arnsworth, Brown and Brownlee[6] all appearing at about the same time.

Continued clinical investigation has proven the first three of these substances of great value. The fourth, polymyxin, has yet to be proven as useful as streptomycin, aureomycin and chloromycetin in clinical application.

STREPTOMYCIN

Streptomycin has proven to be effective against a wide range of organisms. However, in many instances organisms rapidly become resistant to the drug.

Adequate blood levels develop within two hours after intramuscular injection, so that intravenous administration is seldom necessary. Following intramuscular injection streptomycin may be found in most of the body fluids. In the normal subject it is not found in the cerebral spinal fluid, but in meningitis, other than tuberculous, adequate levels

* Presented at the centennial session of the Indiana State Medical Association, at Indianapolis, September 28, 1949.

develop after repeated intramuscular injections. Fifty to 75 percent of the injected dose appears in the urine within twenty-four hours.

When given orally, streptomycin is not absorbed into the blood in appreciable amounts, and almost all of the ingested dose is excreted unchanged in the stool. Likewise, when inhaled into the respiratory tract it is not absorbed into the blood.

TOXIC REACTIONS

Toxic reactions have developed. There is, however, general agreement that when treatment is not prolonged beyond two weeks, toxic reactions have not been serious. With prolonged administration certain neurological disturbances such as vertigo and deafness have occurred. In Keefer's[7] experience with 1,000 cases toxic manifestations developed in 20 percent of the individuals, and the more commonly observed reactions were:

1. Local reactions including irritation at site of injection, tingling and paresthesia.
2. Histamine-like effects, headaches, flushing of the skin, nausea, vomiting and fall in blood pressure.
3. Sensitization reactions; skin eruptions, fever.
4. Neurological disturbances, vertigo, tinnitus, deafness.
5. Miscellaneous: diarrhea, albuminuria, casts, purpura, hemorrhagia, and arthralgia.

However, in October 1948 the report of the Council on Pharmacy and Chemistry[8] indicated that a reduction in dosage showed a marked reduction in toxic reactions without a similar reduction in therapeutic efficiency in tuberculosis. Also the more highly purified dihydrostreptomycin is reportedly freer of toxic manifestations without any loss of therapeutic efficiency.

In pediatric practice streptomycin has become of utmost importance in the treatment of meningitis due to H. influenzae type B, chronic bacillary urinary tract infections, pertussis, tuberculous meningitis, and certain other bacteremias and chronic pulmonary infections not responding to penicillin and/or sulfonamides.

INFLUENZAL MENINGITIS

The infections caused by the H. influenzae are of special interest to physicians dealing with children. About 75 percent of the cases of meningitis caused by this organism occur in the first two years of life. Alexander[9] reported on twenty-five cases treated with intramuscular and intrathecal streptomycin. Keefer[7] reported 100 cases of influenza meningitis treated with streptomycin with seventeen deaths. The majority of the deaths occurred in patients treated by other means for several days and death occurred in 65 percent of the cases after five days or less of streptomycin and all were treated intrathecally. Hoyne[10] in 1948 reported twenty-eight cases with twenty-six recoveries and of these twenty-one received only intramuscular medication. All reporters concur in the opinion that sulfonamides should be used in combination with streptomycin and in severe cases antiserum plus sulfonamides should be employed early in treatment, as a means of combating that small percentage of organisms which may be streptomycin-resistant. The mode of action of streptomycin and the emergence of resistance has been extensively studied by Alexander.[11-12-13]

Since May, 1946 there have been a total of twenty-one cases of influenza meningitis treated in Strong Memorial and Rochester Municipal Hospitals. Of these, seventeen recovered and the last thirteen cases recovered without intrathecal therapy.

Another H. influenzae infection of note is the overwhelming and severe epiglottitis occasionally seen in younger children. This condition is manifested by marked respiratory distress, and a markedly edematous, beefy epiglottitis, and is frequently fatal after a short but severe illness. In this condition we have seen rapid recovery after the institution of streptomycin therapy.

Occasionally laryngotracheobronchitis in infants has its bacteriologic etiology in the H. influenzae. In these cases a definite lowering of the always high mortality rate may be had if streptomycin therapy is instituted in time. Terrell and Hoar[14] have recently reported a series of infants, ranging from two to four months of age, whose condition became progressively worse until institution of streptomycin therapy following the isolation of H. influenzae from these infants. All made a rapid recovery.

URINARY TRACT INFECTIONS

The chronic bacillary urinary tract infections which fail to respond to sulfonamide therapy may be successively combated by streptomycin in many cases. In children these cases are most commonly associated with some anatomical anomaly which leads to urinary stasis and hence infection. Failure of therapy to sterilize the urinary tract may result from marked variation in sensitivity of various strains or to rapid development of resistance. In children, chronic or repeated infection of the urinary tract should suggest some congenital anomaly, and usually in our experience careful urological x-ray examination reveals this to be true. Of the organisms usually found in the urinary tract infections the colon bacillus group[15] of infections have been found to be the most susceptible to streptomycin, while the Streptococcus faecalis and B. pyocyaneus are the least susceptible.

PERTUSSIS

Hemophilus pertussis has been shown to be readily sensitive to streptomycin in levels of 1 to 3 units per 100 cc.[7] and Hegarty, Theile and Verwey,[16] as well as Bradford,[17] have shown streptomycin to be effective in murine pertussis. How-

ever, published reports to date have not been highly conclusive in showing that there is any appreciable alteration in the course of the disease clinically.[18-19] The experience of Doctor Bradford and his associates seems to indicate that when streptomycin is given locally, either as an aerosol or as nasal drops, there is a favorable response when judged by the disappearance of the organisms from the respiratory tract.

TUBERCULOSIS

The possible use of streptomycin in the treatment of tuberculosis became apparent as a result of the early report of the sensitivity of the tubercle bacillus to streptomycin by Feldman and Hinshaw.[20] In the intervening five years, extensive study has shown that many forms of the human disease are benefited by streptomycin. It was at once apparent that two prime factors were to be considered in the use of streptomycin as a therapeutic agent in tuberculosis: (1) toxic side reactions, and (2) development of streptomycin resistance. In an attempt to lessen the percentage of toxic manifestations the tendency has been a gradual reduction in the daily dose[8] from 4 grams to 1 gram daily, without any appreciable loss of therapeutic effect, but at the same time a definite decrease in toxic reactions. Streptomycin-resistance develops usually between the fourth and ninth week of therapy so that gradually the course of therapy has been shortened to offset this danger. The selection of patients to be treated may present a problem to those dealing with adults, but it is much simplified for the pediatrician because the type of the disease encountered is more likely to be in the group in which therapy is mandatory. Certainly tuberculous meningitis, miliary or an acutely disseminated tuberculosis, exudative pulmonary lesions and, to a lesser extent, tuberculosis of the bones or tuberculous lymphadenopathy warrant therapy. One is usually not justified in so treating a primary infection unless there does not seem to be the healing that is generally expected.

Most authors agree that in tuberculous meningitis intrathecal therapy is necessary as an adjunct to intramuscular therapy. Here again there are dissenting opinions, as Levinson[21] has only recently reported on a series of nineteen cases of tuberculous meningitis; eight of the patients were alive at the time of the report, and only one patient received intrathecal therapy. The duration of therapy is undecided, but at the present a period of ninety days seems to be the average. Relapses have occurred and in some instances further therapy has been productive of another remission, while in others it has proven of no value because of streptomycin resistance.

Doctor Raymond Sommers of Rochester, New York, has one patient who was first treated in 1946. Her first course of therapy lasted for ninety days and included intramuscular and intrathecal treatment. She responded well, with clearing of the cerebrospinal fluid and repeatedly negative cultures. However, she relapsed three weeks after therapy was stopped but responded again to a second course of treatment which lasted for 100 days. Three months later a second relapse occurred but again therapy was effective and was continued for seventy-five days. The child has remained well since July 1946. She is completely deaf but whether due to the disease or to streptomycin is difficult to say. It is interesting to note that this child received a total of 212 grams of streptomycin—196 grams intramuscularly and 16 grams intrathecally.

Time forbids any consideration of therapy of other forms of tuberculosis with streptomycin. In a discussion of the subject Pfutze and Pyle[22] state, "Treatment with streptomycin certainly is indicated in every case of disseminated tuberculosis and should be instituted as early in the course of the disease as possible. In tuberculous meningitis the ultimate mortality rate may not be decreased by more than a small percentage, but the remission effected by chemotherapy is often dramatic and may persist for many months."

Streptomycin has proven of no avail in the treatment of typhoid fever. In the other salmonella infections,[23] streptomycin has likewise proven of no value in affecting the clinical course of the disease; although the treatment did in Seligman's[24] report cause a marked suppression of the organism during therapy. Goettsch[25] has reported favorably upon the use of streptomycin in a severe epidemic of infantile diarrhea in which a predominance of Gram-negative organisms of the colon group was isolated.

Streptomycin may prove decidedly beneficial in the treatment of the other forms of bacteremias in which the organisms are resistant to or become resistant to penicillin or sulfonamides.

In certain forms of chronic suppurative pulmonary disease streptomycin in the form of aerosol may be highly beneficial.

We have had no experience with streptomycin in brucellosis. In the reported cases relapses with combined sulfonamide and streptomycin therapy seem to be quite common, but in Spink's[26] experience this has not been due to the emergence of streptomycin resistance. Woodward et al., in a recent summary, have obtained what seems to be a better result with other antibiotics in brucellosis than has been effected with the combined streptomycin and sulfonamide treatment.

Likewise, we have had no experience with the treatment of tularemia with streptomycin. Many reports of the prompt response of tularemia to streptomycin are available.[27-28-29] Woodward[40] states, "Rabbit fever perhaps affords this antibiotic its clearest and most favorable indication for use."

AUREOMYCIN

Time precludes any consideration of the physical properties of aureomycin. This antibiotic has been shown to have strong activity against a wide range of bacteria.[30-31] This activity varies markedly against different species of organisms and different strains of the same organisms. In general aureomycin is more active against cocci than against Gram-negative bacilli but it is highly active against Hemophilus. Pseudomonas aeruginosa and most strains of B. vulgaris appear to be the most resistant of the clinically significant bacterial pathogens. More important is the therapeutically proven activity of aureomycin against all known available Rickettsias and viruses of the psittacosis-lymphogranuloma venereum group.

Interestingly enough, in the studies available at the present time no reports have shown the emergence of an aureomycin-resistant strain of organisms following therapy.

The dosage of this agent is still more or less in the indefinite stage, but in most instances the dose given averages 40 to 50 mgm. per kilogram of body weight daily. It has been shown that adequate blood levels develop after oral administration. Toxic manifestations of serious note, other than rapid drop of blood pressure and cardiac arrest after massive intravenous doses, have not been reported. Local irritation develops about the site of intramuscular injections, and after oral administration, nausea, vomiting or diarrhea are quite frequently encountered.

The clinical conditions in which aureomycin has had sufficient trial, so that we may more or less evaluate its results, are: primary atypical pneumonia, rickettsial infections, typhoid and other salmonella infections, urinary tract infections, infections of the eye and infections of the skin and brucellosis.

PRIMARY ATYPICAL PNEUMONIA

Primary atypical pneumonia has been shown to respond well to aureomycin. In fact, this is the first agent that has offered any aid in the therapy of this condition.

Three reports[32-33-34] including fifty-three cases demonstrate a prompt response to therapy with fever subsiding in twelve to forty-eight hours. We have recently seen a very favorable response in several children whose cold agglutinin titres were significantly elevated. The x-rays presented a typical picture and the bacteriological findings were insignificant. The bacterial pneumonias have also been reported to exhibit a prompt response to aureomycin with rapid improvement.[35-36]

The reported cases of typhoid and other salmonella infections show rather indifferent results. Finland[37] in a summary states that in more than forty-five cases favorable results have been obtained in about one-half, but these results have not been dramatic and in many instances no obvious benefit was demonstrated.

RICKETTSIAL DISEASES

In tick-bite fever, the most likely to be encountered of the rickettsial diseases in this geographical region, there is a definite response, with an average duration of fever of about 2.3 days, and clearing of the rash in four to five days after institution of therapy.[38-39] Aureomycin to date certainly has proven of greater value in the treatment of this disease than para-aminobenzoic acid. Other of the more infrequent rickettsial diseases, such as typhus fever and Q fever, have been reported to respond well to aureomycin.

In treatment of the urinary tract infections aureomycin has been shown to be effective much as are the other chemotherapeutic and antibiotic agents. It has proved effective in some cases of pyuria where the organism has proved resistant to sulfonamides and streptomycin. However, infections caused by Proteus and pyocyaneus have proved resistant to therapy.[41]

BRUCELLOSIS

Acute brucellosis is not frequently encountered in pediatric practice; however, reports to date indicate that the disease responds promptly to aureomycin administration.[42-43] It is to be noted from the earlier reports that relapses did occur, so that now a larger dose—4 to 5 grams daily, and a prolonged period of therapy (two weeks)—is recommended. In May of this year Boyd and Prignana[44] reported the case of a nine-year-old girl successfully treated with aureomycin.

I feel that the use of aureomycin in the pyodermas need not be enlarged upon other than to mention its possibility; particularly if the infecting organism is resistant to penicillin or streptomycin. We have recently had opportunity to use aureomycin in several instances of moderately severe Pyoderma in the newborn. In every instance the lesion cleared promptly without any other therapy and in no instance were there any gastrointestinal symptoms attributable to the drug.

Bacterial conjunctivitis and dendritic keratitis have been reported to respond well to a 0.5 percent solution of aureomycin instilled into the eye.[45]

Aureomycin's antibiotic activity against Hemophilus would suggest that it would be of therapeutic value in the treatment of pertussis. To date studies being carried out by Doctor Bradford and his associates at the University of Rochester have yielded no conclusive evidence.

Aureomycin, like streptomycin, has been shown by Woodward and his colleagues to have a marked beneficial effect upon tularemia without the toxic dangers associated with streptomycin therapy.[46]

In June of this year McVay, Laird and Sprunt[47] published a preliminary report of the use of aureomycin in three cases of amebiasis with excellent results. They add a post note that the number of cases successfully treated has risen to eleven at the time of publication.

CHLOROMYCETIN

The third and last of the antibiotics we shall consider, chloromycetin, has been shown to have its greatest range of usefulness in the rickettsial and Gram-negative infections, particularly those due to Brucellae, the Salmonella and coliform group.[43] This therapeutic agent, like aureomycin, is readily absorbed from the gastrointestinal tract. It may, in contrast to aureomycin, be administered intramuscularly without reaction at the site of injection. Again like aureomycin, no serious side effects have been observed. Prolonged experimental intramuscular administration in dogs has produced marked anemia.

TYPHOID FEVER

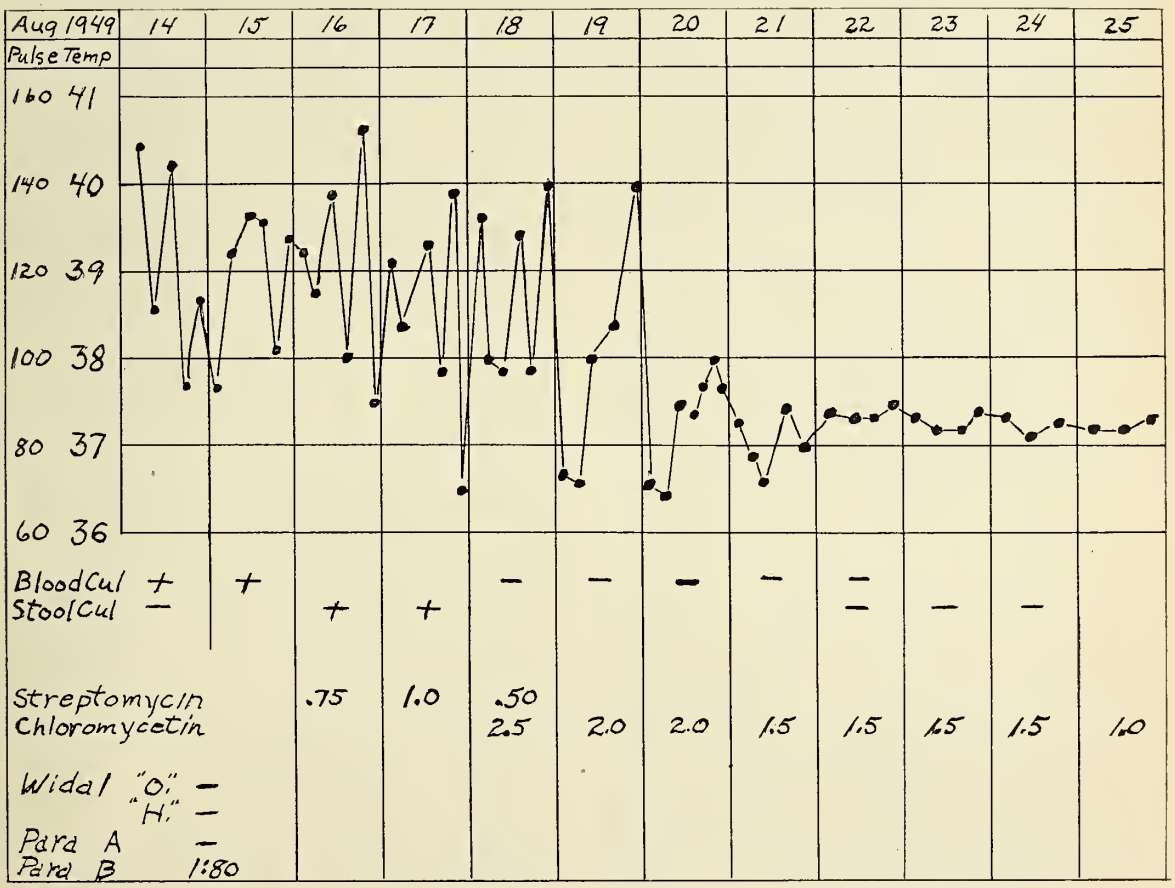
The results of the use of chloromycetin in typhoid fever to date[43] indicate that this agent is more beneficial than aureomycin. In twenty-one cases Woodward reports four relapses, following a relatively prompt initial response. In no instance in which a relapse occurred was the organism found to be chloromycetin-fast by laboratory or clinical results, as in the three cases retreated at the time of relapse a prompt response again occurred. It is also of interest to note that, although these patients responded well to chloromycetin therapy, the danger of the usual complications was not obviated, as they experienced two instances of intestinal hemorrhage and one of intestinal perforation while the patient was still under treatment.

We have recently seen a child with a Salmonella infection from whom a paratyphoid B was isolated, whose course and response to chloromycetin we should like to demonstrate. I believe the beneficial response to the drug is evident from the prompt drop in fever, about forty-eight hours after the drug was started. As you will note the blood culture taken the day chloromycetin was started was negative.

It is to be hoped that further experience will prove that all Salmonella infections, not too infrequently seen in children, are likewise responsive to this therapeutic agent.

The use of chloromycetin in acute brucellosis is as yet too scant to permit the drawing of any conclusions. It has been shown to exhibit a definite and prompt beneficial effect, but the final number of relapses to be expected cannot be stated.

In the rickettsial diseases chloromycetin exhibits the same effect as does aureomycin. Pincoffs et al.[48] have shown the effect of chloromycetin on Rocky Mountain Spotted Fever to be comparable with that of aureomycin.



URINARY TRACT INFECTIONS

The use of chloromycetin in urinary tract infections is being investigated in the Urological Department at Rochester. It is again too early to make any definite statement, but I have been informed by members of the department conducting this study that they feel at present that chloromycetin exhibits a more beneficial effect than does aureomycin. They have found that chloromycetin has shown definite clinical benefit in the Proteus and pyocyaneous infections. In several instances sulfonamides, streptomycin and aureomycin had failed to eradicate such infections, or these organisms have appeared after the clearing of the original bacilluria. Following initiation of therapy with chloromycetin the proteus group, and to a lesser extent the pyocyaneous group, have been sterilized and have so remained to date. Doctor John Benjamin has treated several children who have serious anatomical defects of the urinary tract and in these cases the associated infection is being controlled quite well with chloromycetin without the disturbing gastrointestinal side-effects which were associated with the use of aureomycin.

I wish to mention polymyxin, in closing, only to say that in the reports available upon its use in pertussis a large percentage of cases of albuminuria developed. At the present time, because of the large percentage of nephrotoxic reactions which develop, its use is extremely limited in pediatric practice.

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PLACENTA ACCRETA

A DISCUSSION WITH CASE REPORT

PAUL B. ARBOGAST, M.D.

VINCENNES

PLACENTA ACCRETA is a complication of pregnancy due to an abnormality of placentation in which the placenta is attached directly to the underlying uterine musculature. It is due to a primary atrophy of the endometrium, the decidua basalis being absent. It may be total or partial; the villi may attach themselves to the uterine muscle or even penetrate into the muscular wall. In the former instance the villi attach themselves to the thin layer of the decidua compacta. In the latter, the compacta being absent, the villi burrow directly into the uterus proper, in some cases penetrating completely to the serosa. If merely attached to the uterine wall the condition is called placenta percreta. If the villi penetrate the wall it is designated as placenta increta. Both types of attachment are included in the term placenta accreta.

CLASSIFICATION

Aaberg and Reid[1] have classified placenta accreta into: 1. total, involving the entire placenta; 2. partial, when one or more cotyledons are involved; and 3. focal, when part of a single cotyledon is involved. They state that the coherence of the placenta to the myometrium results from the absence of the decidua basalis, particularly the stratum spongiosum, with either direct contiguity or invasion into the myometrium by chorionic villi.

In his review Phaneuf[2] found that placenta accreta was known to the older obstetricians. The first case was reported by Plater (1536-1614) who described the case of Galla, a noblewoman, who was delivered on March 25, 1588. The afterbirth was retained and the patient died. On autopsy, the placenta was found to be adherent about the internal os indicating the additional presence of placenta previa. The condition was described again by Salzman (1573-1656), and by Bonet (1620-1689). Morgagni (1682-1772) reported a case in which, at the autopsy, the placenta was so firmly attached to the uterus that it was separated only with difficulty, even with a knife. More recently Weille, in 1897, reported a case associated with placenta previa. The patient died after attempted manual extraction. In 1890 Hoffmier reported a case which is presumably the first to show the absence of the decidua basalis histologically. In 1900 Alexandroff reported the first case of placenta accreta to recover. About this time Schwarzenbach reported a case of a placenta implanted on a fibroid. This is believed to be the first primipara reported.

INCIDENCE

The occurrence of placenta accreta, although rare, is not too uncommon and the incidence has been placed at widely varying levels. Irving and Hertig[3] give the incidence as one in 1,956 while the opposite extreme is represented by one in 40,000. A comparison of eleven reports places the average incidence at one in 14,622 deliveries. The low figure of Irving and Hertig is due to their opinion that a large number of such cases are not reported, being treated by uterine dilatation and curettage, and any deaths resulting therefrom charged to hemorrhage or sepsis. It is the writer's opinion that the diagnosis should be restricted to those cases showing the histological criteria of absent spongiosum layer with the villi adherent to, or invading the muscle layer of, the uterine wall. All investigators concurred in the finding that placenta accreta was more common in multipara than primipara, the ratio being about nine to one.

Up to 1925 forty cases of placenta accreta had been reported in the literature, nineteen lived and twenty-one died. From 1925 to 1936 forty-six cases appeared in the literature, thirty-six lived and ten died. From 1936 to 1948 ninety-four additional

cases have been reported, with only three deaths reported. This makes a total of 180 cases, with thirty-four deaths. Fifteen of the total cases reported were associated with placenta previa. Aaberg and Reid have estimated that 11 percent of all retained placentas are placenta accreta.

ETIOLOGY

The etiological factors of the condition, according to the studies of Kwartin and Adler,[4] are: 1. maldevelopment of the uterus with hypoplasia of the endometrium and destructive changes of the properly developed endometrium; 2. excessive growth of the chorionic elements; 3. insufficient antiferment production against the erosive power of the trophoblast, possibly due to deficiency of the hormonic cycle of the maternal organism. Mundt[5] states that the etiology is definitely related to previous endometrial trauma such as previous endometritis, postpartum sepsis, manual removal of the placenta, curettage, myomectomy, or Cesarean section. The causes may be listed as follows: (a) manual removal of the placenta in one or more previous pregnancies with resulting damage to the endometrium; (b) the performances of vigorous or repeated curettages; (c) medication of a destructive and erosive type employed in the uterus; (d) the presence of submucous myomata with consequent atrophy of the overlying mucosa; (e) affections of the endometrium such as endometritis, septic puerperal processes, pyometra; (f) faulty positions of the placenta, placenta previa (g) pregnancy in a uterine diverticulum.

The usual pathological findings, as described by Meyer and Ashworth,[6] are: 1. total or partial absence of whole decidua basalis; 2. absence of either spongy or compact layer; 3. the penetration of epithelial cells, probably of a trophoblastic nature; 4. deep penetration of chorionic villi into the uterine wall; 5. thinning of the uterine wall; 6. changes in the layer of Nitabuch; 7. myometrial tissue drawn up into the decidual septa; 8. degeneration of the myometrium; 9. acute and chronic inflammation; 10. increases in connective tissue formation; 11. condition of the decidua vera (some found it normal, others absent or poorly developed). The spongy layer is deficient or absent.

DIAGNOSIS

Placenta accreta is not too difficult to recognize if the three cardinal diagnostic signs of placental separation are absent; namely, (a) bloody show, (if separation is partial, bloody show is present and profuse hemorrhage may occur); (b) rise of the fundus; (c) descent of the umbilical cord. It is a striking phenomenon that in spite of the fact that there is no severe loss of blood, the RBC of these patients (where reported) varied from 2,400,000 and 2,800,000, with an average Hb. of 47.7 percent. There was no description of a state of shock, the blood pressure levels and pulse rates being about normal, and no explanation has been given as to the markedly lowered RBC and Hb., although the condition appeared to be uniformly present.

TREATMENT

The treatment for placenta accreta is immediate supravaginal hysterectomy, which gives uniformly excellent results. A definite plan of treatment, therefore, should be carried out in all cases of placental retention. Within one-half to one hour following delivery, a diagnosis of a retained placenta should be made. Preparations should ensue for immediate manual removal. This operation should be carried out in an operating room equipped for an immediate laparotomy, as well as for manual removal. After the patient is anesthetized, a Crede expression should always be tried. If this procedure fails, manual removal should immediately be attempted. Uterine packing should be resorted to if there is any question that the uterus is not contracting properly. If a placenta accreta is encountered, the uterus should be packed at once with sulfanilamide gauze and an immediate supravaginal hysterectomy performed. The pack is removed, vaginally, prior to amputation of the cervix. The amount of hemorrhage is markedly reduced by this method. Usually, 10 gm. of sulfanilamide powder is placed under the peritoneal flap covering the cervical stump. Multiple transfusions are usually necessary when the blood loss has been great. If placenta accreta is encountered at Cesarean section the uterus should be removed supravaginally. This should be done to prevent post-partum hemorrhage due to the inability to remove completely the placenta, and secondarily to prevent further pregnancies, as Cesarean section has been given as one of the probable exciting factors.

Manual extraction is extremely hazardous, due to the difficulty encountered in attempting to peel out the placenta, the danger of rupture of the uterus, as well as possible hemorrhage and sepsis. In spite of these hazards, several cases have been reported in which surgery was not done. Smith and Seibert[7] described a case in which the situation was such that at the time the diagnosis was made a laparotomy was absolutely contraindicated, not only by the severe shock but by the evidence of sepsis. Conservative management was the only alternative. Wangensteen duodenal suction was used to relieve the distention. The vaginal discharge became profuse and foul-smelling. A transfusion of 500 cc. of citrated blood was given every other day, from the third to the eleventh postpartum day. On the alternate days 60 grains (4 gm.) of sodium sulfapyridine was administered intravenously in 1 quart (1,000 cc.) of isotonic solution of sodium chloride every eight hours. Five cc. of azosulfamide solution was injected every four hours for two days, and 2 cc. every four hours, intramuscularly. Improvement continued under conservative management to the point where there was no indication for surgical attack when her

general condition would have justified such intervention. Evidently the placenta sloughed out in the profuse, foul discharge, although no portion of it was ever identified. The resumption of normal menstruation after three months supports this assumption. Bosshardt[8] treated a patient by supravaginal hysterectomy nine days after delivery following partial manual extraction. In spite of this hazardous method his patient made a complete recovery. Potter[9] allowed the placenta to remain within the uterus and after a stormy course the patient recovered. Several such cases have been reported.

MORTALITY

When supravaginal hysterectomy alone is performed there have been no deaths reported in the literature. If supravaginal hysterectomy follows attempted manual removal the mortality rate was 18.9 percent. When attempted manual removal was followed by vaginal hysterectomy the rate was 36.4 percent. Attempted removal alone resulted in 58.8 percent mortality rate. Irving and Hertig report 66.6 percent. This figure includes those deaths resulting from dilatation and curettage, performed for retained placenta in accordance with their contention that all such cases are presumably placenta accreta. In the few cases reported recently, all recovered. Four had supravaginal hysterectomy alone, two had supravaginal hysterectomy following attempted manual removal, and two attempted removal alone.

CASE REPORT

The patient, Mrs. S.H., a white female, age 23, primipara, was admitted to the hospital at 7:30 A.M. on 12-22-48 in early labor. The past history may be of some significance. The patient had the usual childhood diseases with good recovery. She submitted to a laparotomy in 1946 in order to encourage pregnancy, at which time a Baldy-Webster uterine suspension was done, cystic portion of the right ovary and the appendix were removed. About sixteen months later small tumors were removed from the breast and the pathological report returned as mild cystic mastitis. Her menses began at the age of thirteen and, following her laparotomy in 1946, were entirely uneventful, urine, blood pressure, serology and blood picture being entirely normal. She gained twenty pounds up to the time of her hospital admission. Her family history was entirely negative.

Physical examination on admission revealed a well-nourished primipara; a well-healed laparotomy scar was noted. Admission temperature was 98.6, pulse 90, respiration 20, blood pressure 115/70, fundus extending to umbilicus, the contractions at intervals of 8 to 10 minutes. She was given seconal and demerol for relief of pain.

Examination at 2:00 P.M. revealed a cephalic presentation, in ROA position, with membrane intact, and about 3 cm. dilation of the cervix. She delivered a 6 pound 8 ounce, living, female infant at 5:58 P.M. The delivery was spontaneous, an episiotomy having been performed. The placenta could not be expressed and manual removal was attempted unsuccessfully. One strip of sulfanilamide gauze was packed into the uterus. A few hours later under general anesthesia the packing was removed and manual extraction again attempted unsuccessfully. The uterus was repacked with sulfanilamide gauze and a diagnosis of placenta accreta made.

At this time the patient's RBC was 2,720,000, Hb. was 43.6, blood pressure 120/70, pulse 122. Shortly thereafter the patient had a chill and her temperature rose to 101.6 F. She was given two pints of whole blood and 1,000 cc. normal saline solution and scheduled for surgery. On 12-27-48 a supravaginal hysterectomy was performed under general anesthesia. The patient's postoperative course was entirely uneventful and she was discharged on the seventh postoperative day. She has been seen at intervals since and has completely recovered, showing no ill effects following her operation. Her blood pressure is normal and she has regained her normal vigor.

The pathology report is as follows: Micro Section: section shows placenta with marked degenerative changes with hyalinization and calcification in many areas. Careful search reveals no evidence of hydatidiform mole. Degenerating decidua vera with marked lymphocytic and poly infiltrate is observed, with an edematous myometrium exhibiting markedly dilated vascular channels. The endometrium is absent. No evidence of malignancy is seen. Diagnosis: Placenta accreta. The accompanying photomicrograph shows in detail the absence of endometrium and the penetration of the uterine musculature by chorionic villi.

SUMMARY

In conclusion, while the etiology of placenta accreta is obscure and the causes varied and inconstant, recognition should be easy if the three classical signs are noted. The treatment by supravaginal hysterectomy has given such consistently excellent results as to warrant no other attempted procedure.

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REACTION TO OVERDOSAGE OF PRIVINE

REPORT OF TWO CASES*

WALTER LEE OWENS, M.D.

BLOOMINGTON

"PRIVINE" (Naphazoline hydrochloride N. N. R.[1]) was introduced in 1942. Fabricant and Van Alyea[2] reported in 1943 on its use, and since then it has become quite popular as a nasal vasoconstrictor. It exerts a prompt and prolonged effect on the nasal mucosa.

Most clinicians have considered "Privine" as a relatively harmless medication with few side effects. However, Waring,[3] Greenblatt,[4] and Hainsworth[5] have recently reported collapse and sedation in children who had received "Privine" in moderate or large amounts. The following report concerns the effects of overdosage with "Privine" on two young women.

CASE REPORTS

Two nurses, Miss J. K., 23 years old, weight 140 pounds, and Mrs. E. D., age 22, weight 116 pounds, both of whom had previously been in good health, acquired "colds" early in March, 1949. For several days they treated themselves with "Privine" nose drops. Nasal congestion became progressively worse, and on the morning of March 10, 1949, both women were very uncomfortable. In an effort to obtain relief, each put two droppers full of 0.1 percent "Privine" solution in each nostril, a total of about four cubic centimeters in each case. In addition, E. D. received short wave diathermy to her face and forehead for about twenty minutes. These procedures gave some relief from the nasal congestion.

About an hour and a half later, both of these women felt dizzy, began perspiring, felt weak and chilly and excessively thirsty. They noted that their pulse rates were somewhat slower than usual. By 11:00 A.M., when they were first examined by a physician, each had a pulse rate of 36 (normal rhythm). J. K.'s blood pressure was 110 systolic, while the diastolic pressure could not be obtained accurately. E. D.'s blood pressure was 110/72. Both patients were weak and became short of breath easily. Their oral temperatures were normal. They were given 65 mg. of caffeine orally, with some improvement in subjective symptoms. Both patients ate lunch at 11:30, and remained in bed after that time. About noon, however, J. K. was weak and very thirsty, and was covered with cold perspiration, while E. D. complained of some dyspnea and a feeling of tightness substernally. Their pulse rates were still about 36, and both were quite pale. Oxygen by nasal mask and caffeine sodium benzoate, 0.25 gm., parenterally, were given to each patient. J. K.'s weakness and E. D.'s dyspnea improved, and oxygen was discontinued after about an hour. Their pulse rates remained about 36, and E. D.'s blood pressure remained about 110/60. J. K.'s blood pressure rose to 174/82, gradually becoming lower after several hours.

Both patients remained completely conscious, showing no evidence of cerebral impairment. Tendon reflexes and coordination were normal. No tremors were evident. There were no signs of abnormal gastrointestinal activity. Heart and breath sounds were normal.

Routine urinalyses were negative. J. K. had a leukocytosis of 12,150, while E. D.'s white cell count was 10,500. Differential counts and hemoglobin levels were normal. Blood sugar (Folin macro-method) at 3:00 P.M. was 131 mg. per hundred cc. for J. K., and 68 mg. per hundred cc. for E. D. Electrocardiograms showed sinus bradycardia in both cases, and in addition, E. D.'s tracing had an inverted T wave in lead CF4, which had returned to normal by the following day.

During the afternoon and evening of March 10, both patients maintained slow pulse rates and remained weak and covered with cold perspiration. J. K. continued to complain of extreme thirst. Both patients developed rebound congestion of the mucosa of the nose, causing them to complain bitterly of headaches. Aside from aspirin compound tablets for the headaches, no further medication was given. Their pulse rates gradually rose to between forty and fifty, and J. K.'s blood pressure dropped to the normal level.

The following morning their pulse rates were

* From the Student Health Service, Kansas State College, Manhattan, Kansas.

from 56 to 74, and their blood pressures were normal. Most of their subjective symptoms were gone, although they felt somewhat weak and still suffered from nasal congestion. On the next morning, March 12, both women were discharged, apparently well except for slight remaining nasal congestion. Repeat electrocardiograms and blood sugar determinations after recovery have shown normal findings. Both women have ceased the use of any nose drops, and are apparently in excellent health one month afterward.

COMMENT

According to Sollman,[6] "Privine" hydrochloride is a potent, long-lasting vasoconstrictor which occasionally produces drowsiness in children and frequently causes "rebound" congestion of the nose. It is not a consistently sympathomimetic drug, but may have cholinergic actions as well (as witnessed by the bradycardia in our patients).

Numerous reports concerning the local[7,8,9,10,11] and systemic[3,4,5] toxicity of "Privine" have been published. If used for short periods of time in small quantities, "Privine" is a very useful drug. If not properly used, it can intensify nasal congestion and can cause alarming systemic reactions.

Physicians are prone to consider nasal vasoconstrictors as innocuous preparations, to be dispensed freely and used at the patient's discretion. While "Privine" is probably as efficacious and as safe as any such preparation, the series of events narrated above should convince anyone that excessive and promiscuous use of "Privine" can produce alarming symptoms.

"Privine" should be used with caution. No reputable physician would think of giving a cardiac patient some digitalis tablets and telling him to "take a few when you feel bad," yet we dispense nasal vasoconstrictors which are equally potent quite casually. It is the purpose of this report to point out some of the dangers from improper use of "Privine."

SUMMARY

"Privine" is a potent nasal vasoconstrictor, dangerous if improperly used. Two cases are reported in which self-medication with approximately four cc. of 0.1 percent "Privine" hydrochloride resulted in bradycardia, weakness, cold perspiration, dyspnea, excessive thirst, hypertension (in one patient), and severe rebound congestion of the nose, lasting several hours. Recovery occurred with symptomatic treatment. "Privine" is a useful but dangerous drug, and should be used with caution.

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A RARE FINDING ASSOCIATED WITH ACUTE APPENDICITIS

Franklin E. Hagie, M.D.

RICHMOND

MRS. E. R., age 58, came to Reid Memorial Hospital October 11, 1942, with acute pain in the right side of the abdomen. The patient had been ill for three days, with right-sided abdominal pain, little nausea, no fever, and constipation. The pain was in the vicinity of McBurney's point, but rather high. The physical findings over the abdomen showed some distention and a mass under and attached to the abdominal wall over the McBurney area. The mass felt about three inches in diameter and was tender on pressure. The leukocyte count was 17,400 and the polys at 83 percent. The urine was negative. Diagnosis of acute appendicitis was made, with abscess formation. No x-ray work was done due to the acute condition, and no x-ray work in reference to the abdomen had ever been done through the years.

The abdomen was opened by a right rectus incision and a mass was found attached to the abdominal wall, with no clear-cut line of cleavage. The impression was that it was either a malignancy or a long-standing, chronic infective area. The mass was cut away from the abdominal wall and a walled-off, gangrenous appendix was removed, con-

Figure 1

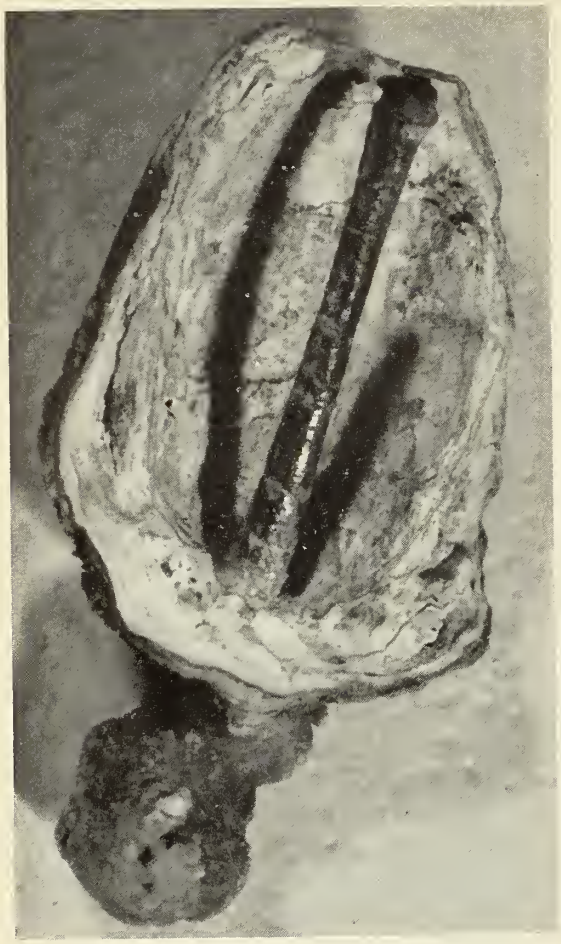
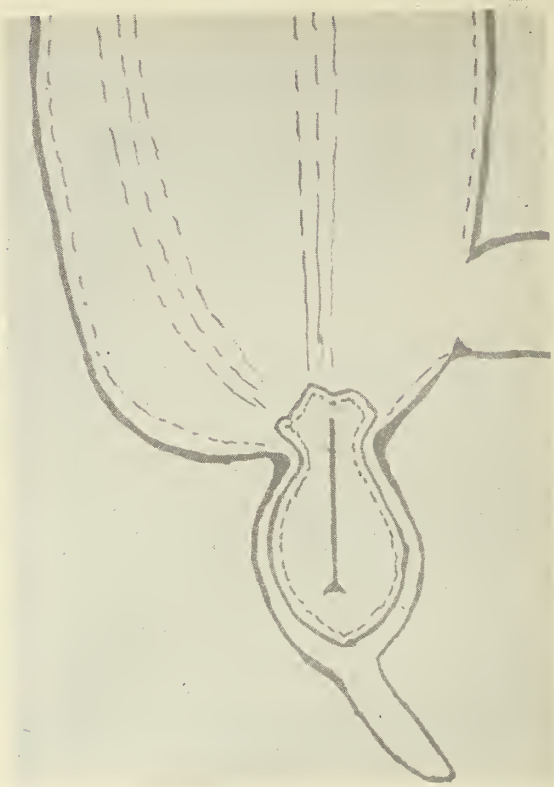


Figure 2



Fecolith with pin

taining a very large, hard fecolith of an odd shape. Part of the head of the cecum had to be removed due to the heavy involvement of the area over a long period of time. Examination of the tissue later showed no evidence of malignancy microscopically, but the diagnosis was a chronic inflammatory mass.

In talking to the husband after the surgery as to the fecolith, he told me that when the patient was a little girl, 8 years old, she had swallowed a pin and it had never been accounted for. Such remarks about foreign bodies are often made to a doctor and we are inclined to pass them over as having no bearing on the matter. After his remark I became convinced that there was something in the hard fecolith, on account of its odd shape. The fecolith had to be opened with a bone forceps, as the shell was very hard. The pin was found in the center with the head down, and I have left the sharp point of the pin fixed in the upper part or tip of the fecolith, as shown in Figure 1. The outer shell was formed of laminated layers of calcium with the area near the pin soft enough to be curetted away. In the diagramatic drawing in Figure 2 is shown the way the fecolith was located in relation to the cecum and the appendix. The fecolith measured one and three-eighths inches long and at the widest point was three-quarters of an inch wide. Patient made an uneventual recovery.

On account of such a peculiar type of a specimen, containing a pin and lying in an appendix for 50 years, I thought this of sufficient interest to warrant reporting.

INDIANA UNIVERSITY MEDICAL SCHOOL LIBRARY

Physicians of the state of Indiana are reminded of the limited loan and reference service recently offered by the Medical School Library. They are invited to visit, telephone or write to the library, where a trained staff will serve them. Upon request, a copy of the regulations governing this service will be sent. Requests may be addressed to: Miss Ruth J. McNutt, General Librarian, Indiana University Medical Center, Indianapolis.

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INDIANA HEART FOUNDATION

THE Indiana Heart Foundation is devoting the entire month of February to the 1950 Heart Campaign. The traditional Heart Week, that week in which Valentine's Day falls, will be especially highlighted with an intensive postgraduate program for physicians (see page 146), and the remainder of the month will be devoted to a membership campaign and solicitation of funds.

The Indiana Foundation was organized a little over a year ago, with physicians and laymen as members, and with the purpose of promoting cardiological research, and improving knowledge and facilities for the treatment of heart disease.

From the funds which are donated to it the Foundation carries on state-wide activities and contributes to the American Heart Association, with which it is affiliated.

During its first full year of activity a well-coordinated program has been planned and carried out. Postgraduate education has been aided by appropriations for a course in cardiology which was conducted at Indiana University School of Medicine, and by the organization and conduct of symposium type programs for county medical societies of the state.

Financial grants have been made to hospitals and clinics for furnishing needed equipment and secretarial assistance. One fellowship in cardiology has been financed during the year just ended.

One of the most important accomplishments was the establishment of a fund for furnishing large amounts of penicillin for the treatment of subacute bacterial endocarditis in patients who cannot afford to purchase the unusually large quantities of the drug needed for this purpose. Four hundred ninety-five million units have been purchased by this fund.

Another of the humanitarian facets of the Foundation's program is its investigation into the possibilities of gainful employment for those persons who are partially disabled by cardiac disease. Rheumatic fever programs are also being organized over the state for the control of this disease.

As it concludes its first year of work the Indiana Heart Foundation is assisting in the organization of county chapters. The county units will supplement the program of the state foundation, and may also perform personal services.

All Hoosiers and particularly Hoosier doctors may be proud of the growth and accomplishments of the Indiana Heart Foundation; it has come a long way in its first year, and merits the continued support and interest of all good citizens.

GRIEVANCE COMMITTEE

ANNOUNCEMENT of the formation of a Grievance Committee by the Indiana State Medical Association has been received by the Hoosier press with many favorable comments. Approval of the plan is based on the fact that the medical profession is not perfect, and that the doctors should be credited with sincerity of purpose when they recognize this fact and provide a means for correcting occasional shortcomings and misunderstandings.

In some instances the plan is needed for another reason. Patients are not perfect either, and some of the criticisms of the medical profession which are current from time to time are due to an unreasonable attitude on the part of the patient, or are a result of distortion of facts.

The only method by which faults of the profession and misunderstandings on the part of patients can be corrected is to make available a group of judicially minded physicians who can collect the facts and determine what, if any, wrong has been done, and who can recommend a solution for the difficulty.

Similar plans have been in operation in other state associations and in large county medical societies, and they have established excellent records. The program of the Alameda County, California, Medical Society has attracted nationwide comment on its success. A like plan in Colorado has improved the public relations of the doctors of that state immeasurably.

A large proportion of all quarrels and disputes, whether medical or otherwise, are due fundamentally to misunderstandings. So it is that the experience of grievance committees in general is that most complaints are either frivolous or can be settled by simple explanation of the facts. Such investigations sometimes emphasize that such programs as emergency medical call services or night and holiday coverage need more publicity, in order that the general public may take advantage of what the profession has provided.

When complaints of excessive fees are taken to such a committee, the patient, after discussing the matter, may find that the charges have been reasonable. At other times the committee may find that the patient has been overcharged and, in the experience of medical grievance committees, the doctors usually are glad to adjust the fee to a figure which satisfies the patient.

Experience also shows that there is an element in the procedure which decreases the number of complaints rather than encouraging them as would seem to be the tendency. All such committees have started off with a rush of business. Later the individuals who complain easily and glibly, after finding that their gripes are subjected to careful and judicious scrutiny, evidently tend to curb their complaining natures unless a genuine cause arises.

Complaints in Alameda County are so few that the medical society carries regular advertising to call the attention of the people to the fact that the medical profession is proud of its medical service, and solicits complaints and constructive criticism.

The value of this in improvng public relations is tremendous. It is also the type of thing which is most helpful in counteracting the propaganda of the socializers and do-gooders. Alameda County cannot be presented by Mr. Ewing as a community in which most of the people cannot afford medical care in a system of free medicine. Its 700,000 people know they are receiving excellent care at a price which they can afford. The county medical society can prove it by the experiences of its medical grievance committees.

ABOUT MEDICAL SOCIETY DUES

READ this first, then "crab" if you still think you want to. The "quote" is from an editorial in the December 1949 *Journal of the Medical Society of New Jersey:*

* * * * *

From the beginning, medical societies have concerned themselves with the ethical, economic and legal status of their members. No doctor is so naive as to have joined his county medical society without knowing that it had an interest in the economic problems of medical practice. We wonder if the doctor who rebels at paying the assessment will also refuse the lower-cost malpractice insurance policy which his membership makes possible? Here is economic benefit arising out of membership.

The issue, actually, is not too complicated. Most of the members of our state society are in favor of the current educational campaign. If you believe in democracy, you accept with good grace the decision of the majority. You exercise your right to oppose the action so long as the question is open for discussion, within the framework of the organization. But if you elect to remain a member, you go along with the majority. You do not try to sabotage the majority decision by arguing that they are all out of step but me. You do not breach the walls of organizational loyalty by appealing to any outside interest over the heads of your fellow-members. You do not say that if you can't have it your way, you won't play ball. You say, rather, that you have voluntarily associated yourself with your colleagues in this society; that by a democratic process they have decided on a course of action; and that good citizenship as well as good sportsmanship requires that you go along with the majority decision. It is the acceptance of an impalatable majority decision which is the real test of faith in democracy.

* * * * *

At our county society meetings very few have said anything against the decisions of their state House of Delegates or of the A.M.A. The ones who complain seldom appear to help frame our policies, —they do their sniping from a distance.

A GOOD DOCTOR*

HOW does one become a good doctor? When one doctor says of another, "He is a good doctor," there is a particular meaning. You will hear the expression used not only about some general practitioners but also about some specialists. As I understand it a good doctor is one who is shrewd in diagnosis and wise in treatment; but more than that, he is a person who never spares himself in the interests of his patients; and in addition he is a man who studies the patient not only as a case but also as an individual.

Diagnosis and treatment are of course the basis of our work with patients. We learn these subjects day in and day out as we walk the hospitals, and we have to pass examinations in them. I do not propose to discuss them except to emphasize that after graduation none of us is infallible; if we accept this fact and are prepared to go on learning, our mistakes will tend to become less frequent and less serious.

How does one learn to devote oneself unsparingly to one's patients? You cannot get this from books or from formal clinical instruction. It is something which is passed on from one generation of doctors to the next, and the easiest way to acquire it is to work with a doctor who already has it in his blood. Lister, for example, was a good doctor: he used to visit his patients in King's every day, including Sundays, and his eminence and his preoccupation with research did not prevent him from showing great understanding and consideration of their feelings.

Your patients need from you more than diagnostic and therapeutic efficiency. They do not come to you to be cured; they come to be relieved of their pains and other symptoms and to be comforted. Given the choice, they would usually prefer a kind doctor to an efficient one. Never forget that the patient and his relations are usually frightened and anxious—upset in their normal life to such an extent that they are prepared to call you into their lives and to tell you the most intimate facts about themselves, though you may be unknown to them except as a member of an honourable profession. In their anxiety, especially when things are not going well for them, they may on rare occasions be rude to you and offend your dignity. This may be hard to bear, especially in the early days of one's medical life before one has lost one's self-consciousness at the bedside and has become wholly familiar with clinical technique. Under such trials you must humble yourself and continue to treat your patient with consideration and kindness, never forgetting for one moment that he is an anxious and overwrought individual, and that in seeking your advice he has paid you the compliment of admitting you to his life and confidence.

* Excerpt from "On Becoming A Good Doctor," by Sir Hugh Cairns, which appeared in the October 8 issue of *British Medical Journal*.

LETTER TO THE EDITOR

There seems to be confusion as to the proper application of the agents now used to treat toxic goiter.

Surgery still remains the best method in all kinds of goiter. Radioactive iodine has not taken the place of surgery in this field. Means recently stated that it may be the accepted agent in diffuse toxic goiter ten years from now; the *experiments* now being made lead to that hope. It is not suitable for treating nodular goiters.

Radioactive iodine cures by carrying enough radiation directly to the gland to produce necrosis. It requires 8,000 to 12,000 r.'s to cause necrosis of the gland. This explains why x-ray treatments of toxic goiter have always been without effect upon the gland, since the radiologist is limited to an ineffective dosage of 1,500 r.'s to keep from burning the skin.

Iodine and propyl thiouracil are both successful now in preparing goiter patients for safe surgery. Neither drug will effect a cure, they only modify the course of the disease by lowering the metabolic rate. Every toxic goiter case should have the B.M.R. reduced by treatment to plus 25 or lower before operation is undertaken.

All toxic goiter patients should be given iodine to prepare them for surgery. Iodine will sometimes bring the B.M.R. down quickly, in that respect differing from propyl thiouracil, which is a slowly acting drug. There is no therapeutic reason for stepping up and stepping down the dose of iodine, such as there is in giving digitalis. There seems to be some relation between the size of the goiter and the dose of iodine needed. Ten drops of Lugol's solution three times daily suffices in most cases. We prefer to give iodine in the form of Lugol's solution so that we are sure we know how much iodine the patient is receiving.

In some cases iodine will fail to reduce the B.M.R. to + 25, our desired level for safe surgery. When this is found to be true, Lugol's solution is discontinued and the patient is given 300 mgs. daily of propyl thiouracil. If within one month the B.M.R. is not reduced sufficiently, the dose is raised to 400 mgs. daily. We have been obliged, in some cases, to go as high as 600 mgs. of propyl thiouracil daily. This is given to the patient in her home without frequent blood counts, which were necessary when the old drug, thiouracil, was used. The patient is seen once a month but is instructed to report any intercurrent disability. Propyl thiouracil is slower in its action than we hoped for; seldom will it bring the B.M.R. rate down one point daily, as was once supposed. Though slow, it will not fail if given in ample dosage. The small doses, which we used timidly at first, merely prolong the preparation period or get the patient to the hospital not ready for surgery.

Sincerely yours,
Goethe Link, M.D.

President's Page

THE PROFESSION AND THE PROPOSITION

IN FEBRUARY we celebrate the birthdays of our greatest presidents, George Washington and Abraham Lincoln. A multitude of loyal Americans—patriots and pioneers, generals and G. I.'s—in the spirit of Washington and Lincoln, have in one way or another sacrificed for the cause of human life and liberty. Because of their free thinking and hard work, the United States has today achieved the world's highest standard of living. Other countries covet, more than anything else, the peace, prosperity, and life expectancy which we take for granted.

We take these things for granted, not because we are selfish and unthinking, but because our forefathers fought and won them for us. They belong to you and to me. Peace, prosperity, and an ever-increasing life expectancy have developed as a direct result of free enterprise; they exist now because of free enterprise; and there is no factual evidence to indicate that they could continue to exist without free enterprise, particularly in the field of medical science where material gain for the individual doctor or scientist is not the motivating force behind his efforts.

But is it advisable to try to explain this to people? I think not. It is too general in its implications. The most effective argument we can set forth against the welfare state and socialized medicine is to relate the cost of supporting such a program from a person's own pocketbook. Let each one of us, then, explain to our patients that there will be no such thing as "free" medical service. Every government service has to be paid for by someone, and the only person responsible is the taxpayer. Taxes are no voluntary matter, and once a taxpayer realizes that "free" medical service is going to cost him dearly, even while he remains well, he may begin to count his blessings, to wonder about the state of the Union, and to consider Mr. Truman's proposition in direct relation to his own income.

To the person who is seeking protection against the expense of accident or sudden illness, suggest Blue Cross and Blue Shield, or some reputable commercial insurance company. Stress the fact that these fine services are available to him at a fraction of the proposed individual cost for socialized medicine and that they are fashioned in the American tradition—to provide freedom of choice for the patient.

Medical Panorama by the Associate Editor

INTERPROFESSIONAL ADVANCEMENT

Last January two of our members, Dr. E. H. Clauser and Dr. C. A. Nafe, spoke before a conference held at Indiana University to consider what Indiana should plan for improvement of its nursing services and its system of nursing education. Both men presented well-pondered material. Doctor Clauser said, in part:

The matter of nurse-physician relation should be kept well in mind. Team work and cooperation are essential, but supervision of all service applicable to the care of the sick must rest with and be the responsibility of the medical profession. This professional relation does not mean that the nurse should be subservient to the physician nor that the physician should stand alone on a pinnacle of knowledge and skill in regard to health matters. The nurse's position on the team might be likened to that of the bacteriologist, physicist, chemist, or pharmacist. These are degree-holding and professionally trained persons, yet the product of their knowledge, when applied to the care of the sick, must be by orders and under the supervision of the physician.

The above is but a sample of Doctor Clauser's presentation, and below is a sample from what Doctor Nafe had to say:

I believe that any program that is outlined for the education of the nurse should have as its basis the bedside care of the sick patient. I do not believe that the suggestion of this report [i.e. the Brown Report], that educational institutions such as universities become the basic centers of nursing education, is a sound principle. Nursing education must not be divorced from the hospital and the sick patient. There should be a well-planned program of coordination between the hospital and the nursing educational program if the proper type of nurse is to be provided.

Those interested will find further material on the nursing situation under Book Reviews. (See page 138.)

MOTHER GOOSE IN THE U. S. A.

The Delaware State Medical Journal reprints the following in its November 1949 number:

THOSE MANY "ISMS"

The Colorado Department of Agriculture recently published the following definition of New Dealism, Socialism, Communism and other isms:

Idealism: If you have two cows you milk them both, use all the milk you need and have enough left for everyone else.

Socialism: If you have two cows, you keep one and give the other to your neighbor.

Communism: If you have two cows, you give both to the Government; then the Government gives you back some milk.

Soft-Pink Communism: If you have two cows, you're a capitalist.

Imperialism: If you have two cows, you steal somebody's bull.

Capitalism: If you have two cows, you sell one cow and buy a bull.

New Dealism: If you have two cows, the government shoots one cow, you milk the other cow, then throw part of the milk down the sink.

Anarchism: If you have two cows, your neighbor shoots one and takes the other.

Nazism: If you have two cows, the government shoots you and takes both cows.

Realism: If you have two cows, they're both dry.

—Wilmington *Sunday Star*, Oct. 23, 1949.

This somehow strikes a familiar chord in our memory, but regardless of that, if these two cows can jump over the moon from Colorado to Delaware, their lesson is worth reprinting in Indiana.

MINNESOTA MUSINGS

Blessings on thee, little man,
Barefoot boy with cheek of tan;
Trudging down the dusty lane
With no thought of future pain;
You're our one and only bet
To absorb the national debt.
Little man with cares so few,
We've got a lot of faith in you;
Guard each merry whistled tune,
You are apt to need it soon,
Have your fun now while you can;
You may be a barefoot man.

* * *

—*Bulletin Hennepin County Medical Society.*

Many a word of truth hath been spoken in jest.

PRINCIPLES OF EARLY MANAGEMENT OF HAND INJURIES*

I. Protection of the Hand

Following injury, the hand is particularly susceptible to the development of complications leading to serious disabilities. For this reason it is important that the freshly injured hand be given the most careful protection against such complications as result from added infection, additional tissue damage and stiffening.

The principles governing the provision of this protection may be briefly stated as follows:

1—Protection against added infection

Any open accidental wound of the hand may be assumed to be contaminated. It is important that no additional infection be added. This requires:

a. Protection of the wound at once with a sterile dressing.

b. Avoidance of putting anything into the wound, such as instruments, gauze, applicators, sponges or any sort of antiseptic.

c. If any cleansing of the areas around the covered wound is done, it should be with soap and water only.

d. Avoidance of all efforts at treatment of the wound by exploration, debridement or repair of damaged structures until adequate facilities are available. Adequate facilities for this purpose should include a location where surgically aseptic technic is employed, adequate anesthesia, proper instruments, sufficient assistance, good lighting and the provision of a bloodless operative field.

e. Application of a sterile dressing which will protect against the entrance of foreign material. Such a dressing should be voluminous, firmly applied with moderate pressure, separating the fingers from each other, and should maintain the hand and fingers in the position of function.

f. Antibiotic drugs should be administered systemically, not locally, in full dosage. Tetanus antitoxin (or toxoid) should be administered when the conditions warrant.

2—Protection against added tissue damage and deformity

Immobilization of the hand is required in any major injury, whether the wound involves skin, tendons, nerves, joints or bones. Immobilization should be governed by the following principles:

a. Immobilization should be employed as soon as possible after receipt of the injury for protection from further tissue damage.

b. Following definitive treatment of the injury, the immobilization should be continued as long as may be required for healing to occur.

c. Immobilization should be in the position of function (position of grasp) in order to maintain optimum relation of bone fragments and soft tissue structures.

d. The position of function in immobilization is necessary to prevent disabling deformities, contractures, muscle weakness and joint stiffening, and to insure the earliest return of usefulness after healing.

e. Flat splinting of the hand or any of its digits must be avoided at all times.

Committee on Industrial Health
Indiana State Medical Association

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* As prepared by the American Society for Surgery of the Hand, and released by the American College of Surgeons.

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

THE NEW DRUGS

Some of the new drugs are proving extremely valuable; some will probably be abandoned after further trial. Some of them are wonderful aids to the recovery of some patients and are not only useless but harmful to others.

All new drugs—and most of the old ones—are dangerous in the hands of unskilled, inexperienced persons. The drug may be right for a certain patient, but the dosage may be wrong.

Drugs are like edged tools—useful for constructive purposes in the hands of workmen who know how to use them, but perilous to life as well as limb if handled inexpertly by people who do not know their dangers.

No one but the qualified physician should give these new drugs. All the drugs have their uses, even the obviously poisonous ones such as opium, strychnine, atropine. But only the physician can tell when to use them and how far to go. He, too, feels his way among the new chemicals, but he has a basic knowledge which assists him, and he knows, or should know, something about the individual patient's bodily structure and reactions. If you are sick, call the doctor. If he gives you sulfa, for instance, he will safeguard it with dosage, timing and other instructions. You cannot take sulfa safely just because someone else did.

Don't buy any drug and take it on your own. You may be dead tomorrow. The doctor's bill costs much less than a funeral, and your family needs you.

—*Kokomo Tribune*

PRESS SEEKS MOTIVE FOR INVESTIGATION

The American Medical Association, along with 16 state and county medical societies, is a target for investigation by the anti-trust division of the justice department. And that has stirred up some very interesting editorial comment in the nation's newspapers.

The Cleveland Plain Dealer observed, "The FBI may find evidence that the medical association has been violating the anti-trust laws because it restricts its membership to those who conform to certain standards and who have passed examinations conducted by state boards. If so, then the FBI might also find that bar associations, dental societies, professional engineers, barbers, cosmetologists and all other organizations whose members are licensed by the states also were in violation of the anti-trust laws."

The Columbus Evening Dispatch said, "The AMA has vigorously opposed President Truman's state medicine proposal. Therefore, the doctors are to be put on the spot, smeared in the eyes of the public and harried by government minions. . . ."

The Los Angeles Times remarked, "It may occur to the general public that if the American Federation of Labor, which openly proposes to raise a large campaign fund to defeat certain members of Congress . . . is not investigated, then the AMA, which has sought to raise a much smaller campaign fund to protect itself from what it considers an assault on medical standards, ought not to be investigated either."

The press seems to be watching this investigation closely, in an effort to learn what motives and purposes lie behind it. The public should do the same thing.

—*New Castle Courier-Times*

'ROBOT' MEDICAL CARE

The president of the Medical Society of Kings county, New York, reflected the point of view of many thoughtful members of that profession when he said that "revolutionary" schemes for promoting medical security, which are now being advocated by some government officials, would tend to create a "robot system" of medical care. He said that his group is opposed to nationalized health insurance because "we are fully cognizant that in countries where medical care has been regimented the medical care is not as thorough, that initiative and incentive for medical research have been stymied, and that setting up a costly regimented system will jeopardize the personal relationship of the patient and the physician."

This is not simply a matter of opinion. It has been factually supported time and time again by the records made in various countries where regimented or socialized medicine has been tried. Science does not flower in a political climate.

The case for government health insurance is without a sound foundation. The problem of caring for the fraction of the population which is actually indigent can be handled without creating another bureaucracy, and without taxing us billions a year to pay the cost. Nothing is ever "free" about government medicine — it is always excessively costly, as well as inefficient. The bill which is now being urged would be no exception to that rule.

—*Lafayette Journal-Courier*

INDIANA PRACTICAL NURSES NOW ORGANIZED ON STATE AND LOCAL LEVEL

THE Indiana State Nurses' Association, recognizing the value of the services of practical nurses in the care of subacute, chronic and convalescent patients, and feeling that the group might be strengthened through organization, took steps a year ago to assist them in forming a state association.

Each of the twelve districts of the Indiana State Nurses' Association was asked to send one of its better qualified practical nurses to a meeting in Indianapolis to discuss the possibility of a state association. The group was definitely interested and an organization meeting was held in Indianapolis on April 6, 1949, with representatives present from all areas of the state. By-laws were adopted specifying that members of the new association must be actively engaged as practical nurses, be 18 years of age or older, in good health, and of good moral character. Members are also required to have had two years (24 months) experience as practical nurses in the past five years, under the supervision of a licensed physician or a registered nurse, or be a licensed practical nurse, either in Indiana or the state from which he or she has come. Application for membership must be endorsed by two persons, either licensed physicians or registered nurses under whose supervision the applicant has worked.

The new association has approximately 450 members and local organizations, which will become constituent parts of the state association, and are already organized in Anderson, Evansville, Indianapolis, Logansport, South Bend, Wabash-Peru, and P.L.S.

The first annual meeting of the Indiana Practical Nurse Association was held in Lafayette on January 19, and the officers who will serve for the coming year are: President—Mrs. Rosa Canter, Evansville; First Vice-President—Mrs. Ruth Spradley, Indianapolis; Second Vice-President—Mrs. Mildred Lake, Elkhart; Secretary—Mrs. Dorothy Slaton, Evansville; Treasurer—Mrs. Lucy Peterson, Lafayette.

PLEDGE COOPERATION OF PHYSICIANS IN COMPENSATION CASES

THE following statement of policy regarding industrial medicine and medical testimony in hearings before the Industrial Board of the State of Indiana was released to the press in January by the Committee on Industrial Health in conjunction with the Executive Committee of the Indiana State Medical Association:

"The physicians of Indiana are ready and willing to assume their responsibility in making the industrial laws of the state function as intended. They wish to cooperate with the claimants, employers, insurance carriers, attorneys and members of the Industrial Board so that cases may be handled promptly and expeditiously.

"The medical profession is cognizant of the legal responsibility placed upon it by the state's industrial laws, and it will endeavor to fulfill this obligation by working with all agencies involved. In return, the profession welcomes and expects cooperation from the other participants. In this way the best interests of all parties will be served.

"Inasmuch as the laws clearly define types of injuries, and clearly set forth the basis for determining percentage of disability or impairment, members of the medical association stand ready to assist and, if necessary, to testify in contested hearings, upon proper notice by either the claimant or the defendant, expressing their opinions in truth exactly as they believe the conditions to be, and without bias or prejudice against either side.

"The medical association commends the Industrial Board for requiring attorneys in contested claims to agree upon a date for hearing. If allowed two weeks to schedule appointments with his regular patients, the physician can most likely arrange his work to be present to testify at the appointed time. It should be remembered that emergencies arise which the physician cannot control, and which may detain him.

"It is unfair to a physician, and makes cooperation impossible, when tactical manipulation by legal counsel places him in a position that he cannot ethically testify for either the claimant or the defendant.

"If full and complete cooperation is received from all parties interested in industrial cases, the medical profession pledges proper medical assistance to every person needing the doctors' help.

"Physicians appearing in behalf of either side should not be expected to cooperate when pressured for perjury of facts. Reputable physicians will testify to the scientific truth, as they believe it to be."

News Notes

The International and Fourth American Congress on Obstetrics and Gynecology will meet at the Hotel Statler, in New York City, May 14-19, 1950. For registration details, housing data and other aspects of the Congress, address inquiries to Dr. Fred L. Adair, 161 East Erie Street, Chicago 11.

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ALEMBERT WINTHROP BRAYTON CLINIC

Dr. Henry Michelson, from the department of dermatosyphilology, University of Minnesota Medical School, Minneapolis, will conduct the Alembert Winthrop Brayton Skin and Cancer Foundation clinic on March 9, at Indianapolis General Hospital. From 8:30 to 9:30 A.M. there will be a discussion of cutaneous tuberculosis, followed by a viewing and discussion of cases. There will be a noon luncheon for the staff and guests, and at 8:00 P.M. there will be a lecture and a discussion of sarcoidosis.

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A second call has been issued for the **Decennial Meeting of the United States Pharmacopoeial Convention**, which will be held at the Hotel Statler, in Washington, D. C., May 9 and 10. Address Adley B. Nichols, 4738 Kingsessing Avenue, Philadelphia 43, for further information.

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The **Northern Tri-State Post Graduate Medical Association**, which includes Indiana, Ohio and Michigan, will holds its 77th annual meeting in Grand Rapids April 11, 1950. A copy of the program may be obtained by addressing Dr. James E. McMeel, secretary, 133 South Main Street, South Bend.

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Cornell University Medical College offers a **Course in Cytologic Diagnosis of Cancer** for doctors only, April 17 to 29. This course will be given under the direction of George N. Papanicolaou, M.D. Tuition is $100. Inquiries may be directed to Dr. George N. Papanicolaou, Cornell University Medical College, 1300 York Avenue, New York 21, N. Y. Applications must be submitted by March 15, 1950.

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The 46th annual meeting of the **National Tuberculosis Association** will be held April 24 to 28, at the Hotel Statler, Washington, D. C. Meeting concurrently with the association will be the American Trudeau Society and the National Conference of Tuberculosis Secretaries. For further information, contact the National Tuberculosis Association, 1790 Broadway, New York 19, N. Y.

OSCAR R. EWING A BLUE CROSS MEMBER

Oscar R. Ewing, outstanding proponent of national compulsory health insurance, is a member of the nonprofit Blue Cross Plans. Recently hospitalized at Duke Hospital, Durham, North Carolina, Mr. Ewing's hospital bill was paid through the interplan bank which provides for Blue Cross members hospitalized outside the area in which they are enrolled. Like 35,000,000 other Americans, Mr. Ewing prefers to prepay hospital bills through the voluntary, nonprofit Blue Cross Plans.

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RESIDENCY TRAINING REQUIREMENTS

The American Board of Obstetrics and Gynecology has not made nor is it contemplating any changes in its residency training requirements, despite rumors of an increase in training years. Eligibility requirements remain the same, namely, three years of acceptable formal training, followed by at least two years of post-training practice in the specialty.

Copies of the Bulletin of this Board, outlining the above requirements in more detail, are available to hospital administrators or to candidates, upon application to Paul Titus, M.D., Secretary, American Board of Obstetrics and Gynecology, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

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THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL POSTGRADUATE COURSES—1950

Brief Review Courses for Graduates in Medicine

Internal Medicine

Diseases of the Gastro-Intestinal Tract	March 13-17
Diseases of the Heart	March 20-24
Rheumatic Disease	March 27-29
Recent Advances in Therapeutics	March 30-April 1
Endocrinology and Metabolism	April 3-7
Diseases of the Blood and Blood-Forming Organs	April 10-14
Allergy	April 17-21
Electrocardiographic Diagnosis	August 28-September 2
Neurology	May 8-11
Ophthalmology	April 24-26
Pediatrics	April 12-14
Roentgenology, Diagnostic	April 17-21

For further information write to Howard H. Cummings, M.D., Chairman, Department of Postgraduate Medicine, Room 2040, University Hospital, Ann Arbor, Michigan.

UNIVERSITY OF MARYLAND LIBRARY Founded 1813 SCHOOL OF MEDICINE

Dr. Herbert L. Egbert, of Indianapolis, was a speaker at the regional meeting of the American College of Surgeons in Belleair, Florida, on January 10. His subject was "Stomach Surgery."

* * *

Dr. J. M. Kercheval has resumed the practice of medicine and surgery in Clinton, after eighteen months on the surgical staff of the VA hospitals in Alexandria, Louisiana, and Biloxi, Mississippi.

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Dr. D. C. Mettler, who has been engaged in the practice of medicine at Ligonier for the past eighteen months, has moved to Auburn to practice. Doctor Mettler is a 1947 graduate of the Indiana University School of Medicine, and spent his internship at St. Joseph's Hospital, in South Bend.

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Dr. Richard H. Russell is now a member of the staff of St. Mary's Hospital, in Evansville, as associate in anesthesiology. A 1945 graduate of the St. Louis University School of Medicine, Doctor Russell served his internship at Indianapolis General Hospital, where he also served a residency in anesthesiology. He practiced for eighteen months in Winamac, and then returned to Indianapolis for additional training in his specialty.

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Dr. Ryland Roesch, who has been in the practice of medicine in Greenfield, has moved to Bicknell, where he is associated with **Dr. Maurice Fox** in the practice of allergies.

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Dr. Paul R. Hawley has resigned as chief executive officer of the Blue Cross and Blue Shield commissions to become director of the American College of Surgeons, effective March 1.

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Dr. Thomas Younan has opened an office for the practice of medicine in Winslow. A graduate of the University of Iowa School of Medicine, Doctor Younan spent six years in the Army, all of which was spent overseas. He received the Medical Combat badge and the Purple Heart.

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Dr. W. D. Gatch, of Indianapolis, has been named to the editorial advisory board of the *G. P. Journal*, which is the new publication of the American Academy of General Practice.

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Dr. Joseph G. Klotz, a 1945 graduate of the Indiana University School of Medicine, is now associated with the Cleveland Clinic, where he will be for four years, taking graduate work in neurosurgery.

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Dr. Earl R. Miller, of Indianapolis, has moved to Williamsport, Pennsylvania, where he has established a practice.

Dr. Bert E. Ellis, of Indianapolis, was chosen president-elect of the American Otorhinological Society at its meeting in New York in November.

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Dr. William W. Dalton, a 1945 graduate of Indiana University School of Medicine, is now associated in the practice of internal medicine with **Dr. Robert M. Vandivier**, at 209 Hume Mansur Building, in Indianapolis.

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After two years in the Army, **Dr. E. Grey Dimond**, a 1944 graduate of the Indiana University School of Medicine, is now in practice in Austin, Texas. He is limiting his practice to cardiology.

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A 1943 graduate of the University of Illinois, **Dr. Boynton H. Booth** is now associated with Dr. Clinton Lane and the Barnard Free Skin and Cancer Hospital, in St. Louis, in postgraduate work. Doctor Booth plans to return to Indianapolis in July to establish a practice.

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Announcement was made recently that **Dr. Joseph E. Coleman** has become associated in practice with **Drs. Harold D. Lynch** and **Eugene W. Austin**, at 216 South Riverside Drive, in Evansville. Doctor Coleman graduated from Indiana University School of Medicine in 1944 and interned at the Indiana University Medical Center. He spent two years in the Army, following which he served as resident at the Riley Hospital in Indianapolis.

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Dr. Dominic F. Chimento has opened an office for the practice of surgery at 910 Hume Mansur Building, in Indianapolis. He graduated from the St. Louis University School of Medicine in 1942, and spent five years' internship and surgical residency at St. Vincent's Hospital, in Indianapolis. He is a veteran of World War II.

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Dr. Robert T. Allen has announced his association in the practice of ophthalmology with his father, **Dr. H. E. Allen**, in Richmond. Dr. Robert Allen spent two years in the Army, and then spent two years at Indiana University Medical Center, in preparation for his specialty.

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Dr. Franklin Bryan has announced the opening of offices at 402 West Washington Boulevard, in Fort Wayne, for the practice of internal medicine. He is a 1942 graduate of Indiana University School of Medicine, and interned at Indianapolis General Hospital, before entering the Army in 1943. Following his separation from the Army, he held a fellowship in medicine at the Indiana University School of Medicine, and then served a residency at Indianapolis General Hospital. In July 1948 he became chief of medicine at the VA hospital in Marion, where he has been since that time.

The American College of Surgeons will hold a sectional meeting in Louisville, on February 20 and 21, with headquarters at the Brown Hotel. The medical profession at large, medical students and hospital personnel are invited to join with the Fellows of the College in the meetings, which will be addressed by nationally prominent visiting and local speakers.

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STERILITY AWARD

The American Society for the Study of Sterility is offering an annual award of $1,000, known as the Ortho Award for an Essay, on the result of some clinical or laboratory research pertinent to the field of sterility. Competition is open to those who are in clinical practice as well as to individuals whose work is restricted to research in basic fields or full time teaching positions. The prize essay will appear on the program of the forthcoming meeting of the American Society for the Study of Sterility, which is to be held at the Sir Francis Drake Hotel in San Francisco on June 24 and 25, 1950. Full particulars may be obtained from the Secretary, Dr. Walter W. Williams, 20 Magnolia Terrace, Springfield, Massachusetts. Essays must be in his hands by April 1, 1950.

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NATIONAL GASTROENTEROLOGICAL ASSOCIATION 1950 AWARD CONTEST

The National Gastroenterological Association again announces its Annual Cash Prize Award Contest for 1950. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

All entries for the 1950 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies accompanied by an entry letter, and must be received not later than June 1, 1950. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

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Dr. W. L. Densford, owner and general manager of *The Indiana Farmers Guide*, and a graduate of the University of Louisville School of Medicine, has gone to England to make a detailed study of socialized medicine as practiced there. His articles will appear in *The Indiana Farmers Guide*.

* * *

The editor of *Life and Health*, a national health journal, announced recently that members of the medical profession are invited to submit 1,500-word articles on medical subjects for publication. The object of the magazine is to keep patients and the public at large well informed on health and medical matters. It specializes on articles written for this purpose by physicians. Further information may be obtained by addressing J. DeWitt Fox, M.D., 6856 Eastern Avenue, Washington 12, D. C.

The John N. Norton Memorial Infirmary of Louisville, Kentucky, recently announced the opening of a department for the treatment of alcoholism. The department is housed in a newly completed addition to the hospital. It will have associated with it the psychiatric service of the hospital, which is affiliated with the University of Louisville School of Medicine. Inpatient treatment of alcoholism will be based on a five-day treatment period, with a fixed fee, and will be conducted so as to encourage association with groups similar to Alcoholics Anonymous for continuing support.

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HOSPITAL INSPECTION PROGRAM

A task force of approximately 100 fire and casualty engineers met January 4 in the Indiana War Memorial Building for final briefing and assignments in the state-wide hospital inspection program.

War has been declared on fire and safety hazards in the hospitals of the nation by the National Board of Fire Underwriters in cooperation with the American Hospital Association, American Medical Association, American College of Surgeons, the Association of Casualty and Surety Companies, National Association of Insurance Agents, International Association of Fire Chiefs, National Fire Protection Association and the insurance rating bureaus of the various states.

The 100 qualified men who will inspect Indiana's hospitals are a part of the 1,700 men who will visit more than 6,000 hospitals of the United States within the next few months for the purpose of preventing fire and other hazards to human safety.

The Indiana Rating Bureau is directing the campaign in Indiana. Cooperating organizations who are furnishing assistance in numerous ways include the Indiana Hospital Association, Indiana State Medical Association, the Indiana State Fire Prevention Association, Indiana Association of Insurance Agents, Western Insurance Bureau, Indiana Fire Underwriters Association, Indiana Fire Chiefs Association and the State Fire Marshal Department.

Reports on conditions affecting life safety found in the hospitals will be given confidentially to the hospitals inspected. The aim of the inspection is to be helpful to hospital authorities in their planning for fire safety. It has been pointed out by those in charge of the program that the survey will not only deal with structural features, but with all other factors affecting fire safety.

Fire departments in the various cities where hospitals are to be inspected have been asked to have a representative of the department accompany the teams of engineers. Thus the local departments can gain some valuable knowledge which would greatly assist them in the event fire did occur in the hospital.

Indiana University News Notes

Hoosier physicians attending the one-day Heart Symposium at the Indiana University School of Medicine, Wednesday, February 15, will hear five widely-known leaders in the field of cardiology. The symposium, presented by the School of Medicine with the cooperation of the Indiana Heart Foundation and the Indiana State Board of Health, is open to all physicians without advance registration or fees.

Speakers announced for the program include: Dr. Arlie A. Barnes, Professor of Medicine, University of Minnesota, and chairman of the Board of Governors of the Mayo Clinic; Dr. Vincent J. Collins, director of the Department of Anesthesia, St. Vincents Hospital of the City of New York; Dr. Harry L. Smith, Professor of Medicine, Mayo Foundation; Dr. Thomas Durant, Clinical Professor of Medicine, Temple University; and Dr. Francis C. Wood, Professor of Medicine (Cardiology) at the University of Pennsylvania.

Registration for the symposium, which will be held in the auditorium of the School of Medicine (1040 West Michigan Street), will open at 9:30 A.M., with the program starting at 10 o'clock. The afternoon session, including a round table in which the speakers will participate, begins at 2 o'clock and the evening session, at which Doctor Wood will speak, is at 8 o'clock.

The Heart Symposium will be followed on February 16 and 17 by a two-day intensive postgraduate course in electrocardiography, offered by the Indiana University School of Medicine and presented by the Department of Cardiology. Enrollment for this course is limited to 25 physicians with a registration fee of $25.00.

This course is designed to review basic concepts of electrocardiography, incorporating the newer leads and their interpretations. Although designed primarily as a basic course, some preliminary knowledge of the subject would be advantageous. Subjects for the two-day session include: History and Application of Technics; Basic Anatomy and Physiology of the Heart; EKG Leads and Waves; Premature Beats; Paroxysmal Fibrillation and Flutter; Electrical Basis and Theory of EKG; Basic ST-S Contours; Five Basic Unipolar Patterns; Anterior and Posterior Myocardial Infarction; Position of the Heart on EKG; Digitalis, Quinidine, Electrolytes; Genesis of EKG Patterns; Anterior and Posterior Myocardial Infarction; Pericarditis; Acute Coronary Insufficiency; Bundle Branch Block; Hypertrophy; Preponderance on Strain; Relationship of Standard and Unipolar Limb Leads; Value of Multiple Precordial Leads; and, Future of Electrocardiography.

Question and answer periods will be held during each session and the course will close with a slide quiz.

Requests for enrollment should be addressed: Recorder's Office, Indiana University School of Medicine, 1040 West Michigan Street, Indianapolis 7.

* * *

An annual two-day cancer program, scheduled for Wednesday and Thursday, April 19-20, is again being presented with the support of the Indiana Cancer Society. Speakers and other arrangements are to be announced in a few weeks.

* * *

The annual Graves Lectures of the Indiana University School of Medicine will be presented in April by Dr. Cyril N. H. Long, dean of the Yale University School of Medicine, and widely known specialist in physiology, biochemistry and endocrinology. The lectures by Doctor Long will be presented on the Bloomington campus and under the sponsorship of the Department of Physiology, probably during the first week of April.

* * *

Appointment of Dr. Edwin A. Lawrence as Professor of Surgery on the staff of the Indiana University School of Medicine, effective January 1, with the additional title of Coordinator of Cancer Treatment and Research, has been announced by Dean John D. VanNuys. Doctor Lawrence has been connected with the Utah University School of Medicine in a similar capacity for the past three years and previously was on the staff of the Yale University School of Medicine. Widely known for his work and publications in relation to tumors and cancer, Doctor Lawrence is a member of the American Association for Cancer Research, American Association for Thoracic Surgery, the Society of University Surgeons, and other professional groups.

100% IN PAYMENT OF DUES

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PERRY COUNTY
PIKE COUNTY
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Deaths

Edward L. Lingeman, M.D., of Indianapolis, died suddenly on January 5, at the age of sixty-two. He was a graduate of Indiana University School of Medicine in 1912, and had practiced in Indianapolis since 1919, specializing in otolaryngology. Doctor Lingeman was a veteran of World War I, and was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.

* * *

Philip S. Titus, M.D., of Fort Wayne, died on December 21, after a long illness, at the age of sixty-six. He graduated from the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1906, and had specialized in surgery. Doctor Titus was a member of the Allen County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Pliny C. Barnard, M.D., of Parker, died on December 16, after a long illness. He was eighty-one years old, and had practiced in Parker for thirty-six years. Doctor Barnard graduated from the Central College of Physicians and Surgeons, in Indianapolis, in 1901, and practiced in Oakville and at Hamilton, before going to Parker in 1913. He was an honorary member of the Randolph County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Everett M. Hurst, M.D., of Cloverdale, died suddenly on January 4. He was seventy-five years of age. A graduate of University of Illinois College of Medicine, in Chicago, in 1900, Doctor Hurst had practiced in Cloverdale for fifty years. He was a member of the Putnam County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

James E. Hughes, M.D., of Indianapolis, died on January 1, after a long illness. He was seventy-one years old. He was a graduate of the Indiana Medical College, School of Medicine of Purdue University, Indianapolis, in 1906, and had practiced in Indianapolis for forty years. He was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Emery Don Lukenbill, M.D., died on December 19, at the age of fifty-five. He graduated from Indiana University School of Medicine in 1919, and had practiced in Indianapolis for twenty-seven years. Doctor Lukenbill was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Harry N. Oldham, M.D., retired physician of Hartsville, died on December 14, at the age of seventy-one. He was a graduate of the Central College of Physicians and Surgeons, in Indianapolis, in 1901.

PHYSICIANS INVITED TO HEAR BRITISH JOURNALIST

Mr. Cecil Palmer, noted British author, editor and journalist, will speak in Indiana on "What Socialism Is Doing To Britain," on the following dates: February 3, South Bend, Central High School Auditorium (evening); February 6, Evansville, Funkhouser Post, American Legion Auditorium (evening); February 7, Indianapolis, Rotary Club, Riley Room, Claypool Hotel (noon); February 8, Indianapolis, Manual Training High School Auditorium (evening); February 10, Gary, Seaman Hall (evening).

Doctors are urged to attend and to encourage others to hear Mr. Palmer.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

December 10, 1949

Roll call showed the following present: C. H. McCaskey, M.D., chairman; W. L. Portteus, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D.; W. U. Kennedy, M.D.; A. F. Weyerbacher, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Byron Emswiller, attorney; Ray E. Smith, executive secretary, and J. A. Waggener, field secretary.

Guests: J. Neill Garber, M.D., chairman, 1949 Committee on Centennial Arrangements; Clyde G. Culbertson, M.D., chairman, Committee on Scientific Exhibits; Prof. Harold E. Smith and Prof. Lynn Robertson, Department of Agricultural Economics, Purdue University; A. S. Giordano, M.D., and H. G. Hamer, M.D., delegates to the American Medical Association.

Statements of receipts and expenditures for October and November for the association and THE JOURNAL were approved.

Membership Report

Number of members November 30, 1949	3,747*
Number of members November 30, 1948	3,673
Gain over last year	74
Number of members December 31, 1948	3,689

* Includes 36 in military service (gratis)
189 honorary members

Treasurer's Office

The treasurer reported that George S. Olive and Company had been engaged to make the annual audit of the books.

On motion of Drs. Ellison and Kennedy, the treasurer is to re-invest the money from securities that are due for redemption in bonds of his choice.

1949 Annual Session, Indianapolis, September 26-29, 1949

Dr. Garber, chairman of the Committee on Centennial Arrangements, submitted his final financial report, returning $2,093.54 of the $10,000 appropriated to the committee. On motion of Drs. Ellison and Black, the executive secretary was directed to write a letter to Dr. Garber and his committee, expressing the genuine appreciation of the association for the excellent manner in which they handled the convention arrangements.

Preservation of centennial material. The task of preserving centennial session material and records was assigned to the executive secretary.

Instructional Courses Committee report. Report of the Committee on Instructional Courses showing a net income of $94.47 was read. The executive secretary was instructed to write a letter to the co-chairmen of the Committee on Instructional Courses, thanking them for the fine work they did in arranging the 1949 program of instructional courses.

1950 Annual Session, French Lick, September 25-27, 1950

Scientific exhibit. By consent the committee decided to have a scientific exhibit at French Lick, featuring Hoosier displays.

1951 Annual Session, Indianapolis

The dates of Monday, Tuesday and Wednesday, October 29, 30 and 31, 1951, were selected for the 1951 annual session. In the event that Monday, Tuesday and Wednesday, October 8, 9 and 10 become available, it was understood that these dates are to be substituted.

Indiana A.M.A. Campaign Coordinating Committee

A letter from the National Economic Council, Inc., offering the services of Cecil Palmer, English journalist and lecturer, for speaking engagements during March and May was referred to the Indiana A.M.A. Campaign Coordinating Committee.

The chairman of the Indiana A.M.A. Coordinating Committee and the field secretary reported on activities of the committee since the last Executive Committee meeting.

Committee on Mental Health

A letter from the chairman of the Committee on Mental Health, outlining its program for 1949-50, was read and referred to the Council.

Committee on Rural Health

After reading a letter of endorsement from the chairman of the A.M.A. Committee on Rural Health and presentation of details of a proposed study of health and medical care practices of rural families by Professors Harold E. Smith and Lynn Robertson, the project was approved, on motion of Drs. Black and Kennedy.

On motion of Drs. Ellison and Black, the chairman of the Indiana Committee on Rural Health was authorized to attend the annual Rural Health Conference in Kansas City, February 3 and 4, 1950.

Organization Matters

Report on A.M.A. Interim Session. Drs. Hamer and Giordano reported on the action of the A.M.A. House of Delegates at the recent session held in Washington. The committee authorized the delegates to prepare a letter to be mailed to the membership explaining the establishment of $25.00 A.M.A. annual dues. On motion of Drs. Portteus and Kennedy, the headquarters office was authorized to decide upon the procedure to be used in the collection of these dues.

Industrial Health Committee report. A statement on the medical profession's position regarding cases before the State Industrial Board was approved on motion of Drs. Ellison and Weyerbacher.

The executive secretary reported the adoption of the Blue Cross-Blue Shield plan by Indiana University for its employees.

Disability Income Insurance. Letter from the president of the Disability Income Insurance Company regarding adoption of standards by the association for disability insurance was read. On motion of Drs. Ellison and Portteus, the suggestion was laid on the table.

Suggestion of the associate editor of THE JOURNAL that Indiana consider a program of education for children of Indiana medical officers killed in World War II was tabled, on motion of Drs. Ellison and Portteus.

Membership in the American Public Health Association for 1950 was approved.

The Journal

Report on advertising:

Increases to November 30, 1949	$ 119.15
Decreases	11.90
Total increase for November	$ 97.25
Total increase for year	$4,565.30

The Bettman Archive

The nausea, vomiting and dizziness of motion sickness may be prevented or relieved, in a high percentage of cases, with Dramamine* (brand of dimenhydrinate).

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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Medical Defense

Reference Committee recommendation. On motion of Drs. Ellison and Weyerbacher, the chairman of the Executive Committee was directed to name a sub-committee to consider the recommendation of the 1949 Reference Committee on Amendments to the Constitution and By-Laws "that the Executive Committee study the question of limiting the indemnity to the assured for his personally chosen attorney to a fee of $75.00 a day in medical defense suits."

The chairman announced that he would not accept re-election to membership on the Executive Committee in 1950.

Because of his absence from the city at the time of the next meeting, the chairman directed Dr. Portteus to preside as chairman of the committee.

There being no further business, the Executive Committee adjourned to meet again at 1:30 p.m., Saturday, January 14, 1950, at the Columbia Club.

COMMITTEE ON PUBLICITY

December 2, 1949

Present: Marlow W. Manion, M.D., chairman; Homer G. Hamer, M.D., James O. Ritchey, M.D., all members of the committee.

Guests: Dr. John D. Van Nuys, dean of the I. U. School of Medicine; Dr. Frank B. Ramsey, editor of THE JOURNAL; Ray E. Smith, executive secretary; and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of January 16—"Chew Food Well."
Week of January 23—"Yellow Jaundice."
Week of January 30—"The Gallbladder."

A news release for local papers and press associations on "Delegation from State to Attend Medical Meeting," having to do with clinical session of the A.M.A. in Washington, December 6 to 9, 1949, was approved.

A new radio transcription entitled, "The Living Proof," produced by the Bureau of Health Education, A.M.A., was selected for use on WFBM when the present series of programs is concluded.

A letter from Ralph P. Creer, Secretary of the Committee on Medical Motion Pictures of the A.M.A., which contained the information that the March of Time films, "Modern Surgery" and "New Frontiers of Medicine," are not available for use on television, was read.

The committee previewed seven films to see whether they were suitable for use on WFBM's television station under sponsorship of the state medical association, with the following decisions:

1. "Disease on Life"—Approved with deletion of portion showing man suffering heart attack.
2. "I Never Catch a Cold"—Approved.
3. "Louis Pasteur, The Benefactor"—Approved.
4. "Help Wanted"—Not thought suitable.
5. "Immunization"—Disapproved; not suitable.
6. "Let's Open Our Eyes"—Not approved.
7. "Heart and Circulation"—Not suitable.

The secretary of the committee was directed to offer other Indianapolis radio stations radio transcriptions.

COMMITTEE ON PUBLICITY

December 16, 1949

Present: Marlow W. Manion, M.D., chairman; Homer G. Hamer, M.D., James O. Ritchey, M.D., and J. A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of February 6—"Psoriasis."
Week of February 13—"Pulmonary Pneumonia."

Three general news releases were approved for use as follows:

December 31—"Doctors Suggest Resolutions for Keeping Healthy."
January 3—"Medical Profession Organizes Committee To Hear Grievances."
January 4—"Doctors Pledge Cooperation in Speeding Industrial Cases."

A letter from *Coronet* was read in which they refused to grant permission for using their films on television programs.

An invitation to participate in the Institute for Education by Radio at Columbus, Ohio, May 4-7 was read. No action taken.

A letter from the AMA confirming booking of the new radio transcription series "The Living Proof" as soon as released, was read.

LOCAL SOCIETY REPORTS

LOCAL SOCIETY OFFICERS

ADAMS COUNTY MEDICAL SOCIETY
President, James M. Burk, Decatur,
Vice-President, Roland L. Reppert, Decatur,
Secretary-Treasurer, Myron L. Habegger, Berne.

ALLEN COUNTY MEDICAL SOCIETY
President, A. P. Hattendorf, Fort Wayne,
Vice-President, Paul L. Stier, Fort Wayne,
Secretary, S. C. Michaelis, Fort Wayne,
Treasurer, G. A. McDowell, Fort Wayne.

BOONE COUNTY MEDICAL SOCIETY
President, L. M. Headley, Lebanon,
Vice-President, A. D. Schaaf, Jamestown,
Secretary-Treasurer, Jack Porter, Lebanon.

CASS COUNTY MEDICAL SOCIETY
President, E. L. Hedde, Logansport,
Vice-President, Foss Schenck, Logansport,
Secretary-Treasurer, John C. Jones, Logansport.

ELKHART COUNTY MEDICAL SOCIETY
President, Arthur W. Kistner, Elkhart
Vice-President, Herbert C. Schlosser, Elkhart,
Secretary-Treasurer, George R. Bloom, Elkhart.

FAYETTE-FRANKLIN COUNTY MEDICAL SOCIETY
President, Walter Foreman, Brookville,
Vice-President, L. N. Ashworth, Connersville.
Secretary-Treasurer, R. H. Elliott, Connersville.

GREENE COUNTY MEDICAL SOCIETY
President, H. B. Turner, Bloomfield,
Vice-President, William F. Craft, Linton,
Secretary-Treasurer, R. E. Moses, Worthington.

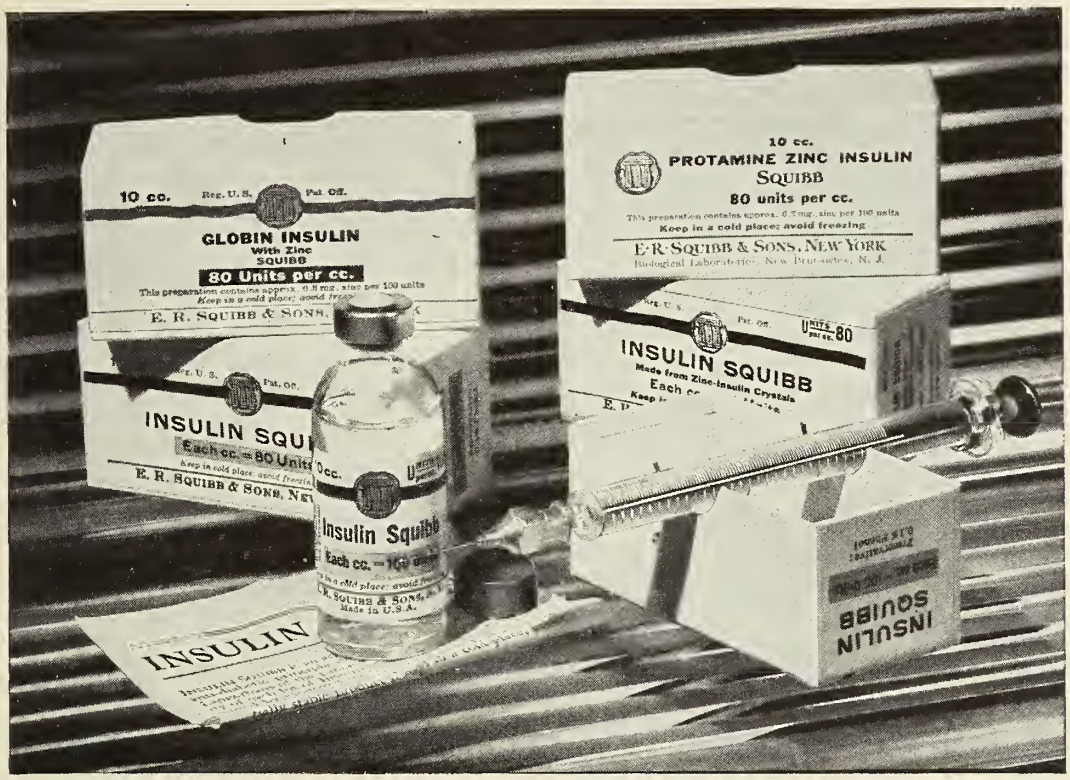
KNOX COUNTY MEDICAL SOCIETY
President, Virgil C. McMahan, Vincennes,
Vice-President, Herbert O. Chattin, Vincennes,
Secretary-Treasurer, Carl L. Green, Vincennes.

KOSCIUSKO COUNTY MEDICAL SOCIETY
President, Dan L. Urschel, Mentone,
Vice-President, R. J. McIlroy, Claypool,
Secretary-Treasurer, George Haymond, Warsaw.

LAKE COUNTY MEDICAL SOCIETY
President, O. L. Marks, East Chicago,
Secretary, David B. Templin, Gary.

LAWRENCE COUNTY MEDICAL SOCIETY
President, William M. Strickland, Mitchell,
Vice-President, John P. Scherschel, Bedford,
Secretary-Treasurer, Donald M. Kerr, Bedford.

NOBLE COUNTY MEDICAL SOCIETY
President, Harold O. Williams, Kendallville,
Vice-President, Joseph D. Seybert, Kendallville,
Secretary-Treasurer, Frank W. Messer, Kendallville.



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intermediate action: peak effect in 8 to 12 hours, with action continuing sometimes for 16 or more hours.

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President, Milton H. Omstead, Petersburg,
Secretary-Treasurer, James L. Higgins, Petersburg.

SHELBY COUNTY MEDICAL SOCIETY
President, D. B. Silbert, Shelbyville,
Vice-President, R. C. Miller, Shelbyville,
Secretary-Treasurer, R. M. Nigh, Fairland.

ST. JOSEPH COUNTY MEDICAL SOCIETY
President, K. T. Knode, South Bend,
Vice-President, P. E. Haley, South Bend,
Secretary-Treasurer, M. I. Hewitt, South Bend,
Assistant Secretary-Treasurer, Verna Christophel, Mishawaka.

TIPTON COUNTY MEDICAL SOCIETY
President, Harold Ericson, Windfall,
Secretary-Treasurer, Meredith Gossard, Tipton.

VANDERBURGH COUNTY MEDICAL SOCIETY
President, Philip E. Yunker, Evansville,
President-Elect, Charles P. Schneider, Evansville,
Treasurer, Morton Helper, Evansville.

WABASH COUNTY MEDICAL SOCIETY
President, James L. Walker, LaFontaine,
Vice-President, James G. Kidd, Roann,
Secretary-Treasurer, William Dannacher, Wabash.

WARRICK COUNTY MEDICAL SOCIETY
President, I. L. Faith, Newburgh,
Secretary-Treasurer, J. H. Purcell, Boonville.

WHITLEY COUNTY MEDICAL SOCIETY
President, Otto Lehmberg, Columbia City,
Vice-President, E. A. Hershey, Churubusco,
Secretary-Treasurer, Frank Thompson, Columbia City.

Boone County Medical Society members met at Witham Hospital, in Lebanon, on December 6. Thirteen members were present for election of officers.

Cass County Medical Society members held a meeting at St. Joseph's Hospital, in Logansport, on December 16. Twenty-four members were present. A sound film on fractures was shown, and Dr. John Larson, of Logansport State Hospital, spoke on brain surgery for psychosis.

Clay County Medical Society members held a meeting in Brazil on December 13. Ten members were present.

Clinton County Medical Society members met at the Clinton County Hospital, on December 6. Dr. A. G. Chittick, of Frankfort, showed a film of the history of the physicians of the Clinton County Medical Society for the past sixty years. Officers for 1950 were elected. The dentists of the county were guests of the society at this meeting, and twenty-seven members and guests were present.

Fayette-Franklin County Medical Society members held a meeting at the Country Club in Connersville on December 12. Seventeen members were present to hear Dr. W. U. Kennedy, of New Castle, speak on socialized medicine.

Floyd County Medical Society members met at the Legion Home in New Albany on December 9, when election of officers was held. Dr. Martha O'Malley, of Indianapolis, the guest speaker, discussed the need for additional hospitals throughout the state.

Fort Wayne (Allen County) Medical Society members held a meeting in Fort Wayne on December 6. The guest speakers were Drs. J. O. Ritchey and Frank B. Ramsey, of Indianapolis, who discussed diseases of the gallbladder, liver and pancreas. Fifty members were present.

Greene County Medical Society members held a business meeting at the Freeman Greene County Hospital in Linton on December 15. Eighteen members were present.

Hendricks County Medical Society met at Avon on December 13. Election of officers was held, and Dr. Palmer Eicher, of Indianapolis, discussed "Commonly Misdiagnosed Fractures and Low Back Pain."

Huntington County Medical Society members met at the Hotel La Fontaine, in Huntington, on December 6. Thirty-four members were present to elect officers for 1950.

Knox County Medical Society members elected officers for 1950 at their meeting in Vincennes on December 20. Dr. George W. Willison, of Evansville, was the guest speaker. His subject was "Cardiac Arrhythmias." Twenty members were present.

LaPorte County Medical Society members held their annual Christmas Party at Welkers Farm, in Michigan City, on December 15. Sixty-four members and guests were present. Officers for 1950 were elected.

Lawrence County Medical Society members met at Dunn Memorial Hospital, in Bedford on December 7. Sixteen members were present to elect officers for 1950.

Noble County Medical Society members met at Kendallville, on December 13, to elect officers for 1950. Fourteen members were present.

Orange County Medical Society members met at West Baden Springs Hotel, in West Baden, on December 6. The guest speaker was Dr. H. Lester Reed, whose subject was "Recognition of Spinal Cord Lesions." Nine members and three guests were present.

Pike County Medical Society members held a business meeting in Petersburg on December 20. Six members were present.

Randolph County Medical Society members held their Christmas dinner meeting at the Elks Club in Union City, on December 12. Twenty-one members were present.

Shelby County Medical Society members met at Shelbyville on December 14. Sixteen members were present.

Tippecanoe County Medical Society members met at Lincoln Lodge, in Lafayette, on December 13. Dr. F. S. Crockett, of Lafayette, spoke on "Some Observations on European Medicine." Sixty-five members were present.

Vanderburgh County Medical Society members held a meeting at the Hotel McCurdy, in Evansville, on December 13. The guest speakers were James A. Waggener, field secretary, and Mr. R. S. Saylor, executive vice-president of Blue Shield.

Warrick County Medical Society members met in Newburgh on December 14. Officers for 1950 were elected. Five members were present.

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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

BOOKS RECEIVED

X-RAY TREATMENT. Its Origin, Birth and Early History. By Emil H. Grubbe, M.D., Chicago. 154 pages, with 51 illustrations. Price $3.00. The Bruce Publishing Company, Minneapolis, 1949.

THE EYE AND ITS DISEASES—by 92 International Authorities. Edited by Conrad Berens, M.D. 2nd edition. 1092 pages, with 436 figures, 8 in colors. Price $16.00. W. B. Saunders Company, Philadelphia, 1949.

DIAGNOSIS AND TREATMENT OF BRAIN TUMORS AND CARE OF THE NEUROSURGICAL PATIENT. By Ernest Sachs, M.D., Research Associate in Physiology, Yale University, New Haven. 2nd Edition. 552 pages, with 348 illustrations and 10 color plates. Price $15.00. The C. V. Mosby Company, St. Louis, 1949.

DISEASES OF THE HEART. By Charles K. Friedberg, M.D., associate physician Mt. Sinai Hospital, New York. 1081 pages with 79 figures. Price $11.50. W. B. Saunders Company, Philadelphia, 1949.

NORMAL VALUES IN CLINICAL MEDICINE. By F. William Sunderman, M.D., professor of Experimental Medicine and Clinical Pathology, University Texas Postgraduate School of Medicine; and Frederick Boerner, V.M.D., late associate professor of Clinical Bacteriology, Graduate School of Medicine, University of Pennsylvania. 845 pages with 237 figures and 413 tables. Price $14.00. W. B. Saunders Company, Philadelphia, 1949.

HANDBOOK OF MEDICAL MANAGEMENT. By Milton Chatton, M.D., Instructor in Medicine, University of California Medical School, San Francisco; Sheldon Margen, M.D., Clinical Instructor in Medicine, University of California Medical School, San Francisco; and Henry D. Brainerd, M.D., Assistant Clinical Professor of Medicine and Pediatrics, University of California Medical School, San Francisco. 480 pages. Price $3.00. University Medical Publishers, Palo Alto, California, 1949.

ALLERGY IN RELATION TO OTOLARYNGOLOGY By French K. Hansel, M.D., Editor-in-Chief, Annals of Allergy. 77 pages, with 6 color plates. Price $2.50. Bruce Publishing Company, Minneapolis, 1949.

FROM THE HILLS. An Autobiography of a Pediatrician. By John Zahorsky, M.D. 388 pages. Price $4.00. The C. V. Mosby Company, St. Louis, 1949.

HUMAN GROWTH. The Story of How Life Begins and Goes On. By Lester F. Beck, Ph.D., Associate Professor of Psychology, University of Oregon. 124 pages, with 39 illustrations in color. Price $2.00. Harcourt, Brace and Company, New York, 1949.

PHYSIOLOGY OF HEAT REGULATION and the Science of Clothing. Edited by L. H. Newburgh, M.D., Professor of Clinical Investigation, the Medical School, University of Michigan. 457 pages with 78 figures and 38 tables. Price $7.50. W. B. Saunders Company, Philadelphia, 1949.

ESSENTIALS OF OBSTETRICAL AND GYNECOLOGICAL PATHOLOGY. By Robert L. Faulkner, M.D., Assistant Professor of Gynecology, the Western Reserve Medical School; and Marion Douglass, M.D., formerly Assistant Professor of Gynecology, the Western Reserve Medical School. Second edition. 357 pages, with 300 illustrations, including 3 color plates. Price $8.75. The C. V. Mosby Company, St. Louis, 1949.

THE PHYSIOLOGY OF THOUGHT. By Harold Bailey, M.D., Charles City, Iowa. 313 pages. Price $3.75. The William-Frederick Press, New York, New York, 1949.

BOOKS REVIEWED

THE COMPLEAT PEDIATRICIAN. Practical, Diagnostic, Therapeutic and Preventive Pediatrics. By W. C. Davison, M.D., Professor of Pediatrics, Duke University School of Medicine. 256 pages. Cloth. Price $5.00. Duke University Press, P. O. Box No. 3701, Durham, North Carolina.

This volume is undoubtedly the most valuable book, both for ready reference during busy office practices, and for study and diagnosis of the difficult case.

The additions and changes of this edition bring it up to date on newer methods of therapy and recent changing concepts of disease. Especially valuable are the many helpful descriptions of simple procedures constantly needed in the unusual situations found in pediatric practice.

Anyone seeing and treating children will find this book extremely helpful and valuable.

R. E. M.

MEDICINE OF THE YEAR. First issue, by Hugh J. Morgan, M.D., Professor of Medicine, Vanderbilt University; Frank Whitacre, M.D., Professor of Obstetrics and Gynecology, University of Tennessee; Henry G. Poncher, M.D., Professor of Pediatrics, University of Illinois; Warren H. Cole, M.D., Professor of Surgery, University of Illinois. 143 pages. Cloth. Price $5.00. J. B. Lippincott Company, East Washington Square, Philadelphia, Pennsylvania.

This book is a review of the major specialties, is destined to be one of the outstanding harbingers of the current trends in medicine and surgery each year. It is written in a free-flowing and readable narrative fashion which is so desired by many of us who find ourselves too busy to read a more laborious style. As a springboard to more detailed discussions, it is excellent; thus, it is easier to choose what one wishes to read in detail. Probably the most important subject is the antibiotics. The writers exhibit the new possibilities in therapy with them, yet add the necessary words of caution.

Since each specialty is written by an authority in that particular field, it is self-evident that we are reading what might be considered the essence of new developments, and new uses for the old.

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WHAT SHOULD INDIANA PLAN IN RELATION TO RECOMMENDATIONS IN NURSING, FOR THE FUTURE? Proceedings of the Workshop held at Indiana University January 5 to 7, 1949. 85 pages. Paper. Price $2.50. Indiana University, Bloomington, Indiana.

This monograph is unfortunately very hard on the eyes. It is physically the most difficult bit of reading your reviewer can remember. **However,** let this not detract from the value of the work, since it was evidently a very earnest group which met January 5, 6 and 7, 1949, to discuss the above-mentioned subject. This conference grew out of certain challenges set forth in Dr. Brown's book, or report, entitled "Nursing for the Future," commonly called the Brown Report on the National Nursing School Study, and its proceedings are reported in the monograph.

The subject was approached from all possible angles by different speakers, each representing the point-of-view of a group or institution interested in nursing. Then the conference was divided into four groups which acted as committees of reference and made specific recommendations which were finally presented to the full convention. The latter then modified these recommendations as it saw fit and finally arrived at an outline of what Indiana should plan for improvement of its nursing services and its system of nursing education. A plan for implementing the proposals was then discussed, the one favored being a steering committee. Suggested representation on this committee included the following:

Indiana State Medical Association.

Indiana Hospital Association.

Indiana State League of Nursing Education.

Indiana State Nurses' Association.

Indiana State Board of Examination and Registration of Nurses.

Indiana Committee of the North Central Association.

The Association of Collegiate Schools of Nursing.

The public.

The speakers at the opening of the conference set forth their "reactions to the Brown Report" from the standpoint of a physician (Dr. E. H. Clauser and Dr. Cleon A. Nafe), the hospital administrator, the "patient or potential patient," the director of a school of nursing, the college administrator, and the university administrator. A few of the recommendations are as follows (much condensed):

I. A. Initiate basic research in nursing service.

B. Develop better interprofessional and public relationships.

C. Recognition and appropriate financial return for the general staff nurse commensurate with her skills.

D. Survey to determine quantity of all types of nursing personnel needed in Indiana.

II. A. Prompt consideration of establishment of four-year degree curricula for basic nursing education, which could be followed by graduate nursing education of university caliber.

B. Initiate immediately curricula for preparation of the practical nurse.

C. Continue and improve the present three-year hospital curriculum.

D. Provide educational living and working environment in nursing education institutions which will attract and hold the type of student needed.

A. W. C.

THE USES OF PENICILLIN AND STREPTOMYCIN—By Chester Scott Keefer, M.D., Wade Professor of Medicine, Boston University School of Medicine, 72 pages. Cloth. Price $2.00. University of Kansas Press, Lawrence, Kansas, 1949.

This small volume consists of a series of lectures summarizing the knowledge of our two greatest antibiotics, penicillin and streptomycin, by a man well qualified to discuss the subject. The material contains little that has not already been published but is well summarized and, therefore, makes an excellent source of information for one not desiring to consult the medical journals. The chapter on streptomycin contains a very complete table of sensitivity of various organisms. The final chapter consists of a brief but readable history of the development of antibiotics, which may prove extremely valuable to the physician asked to present this subject to a lay group.

HANDBOOK OF MATERIA MEDICA, TOXICOLOGY, AND PHARMACOLOGY—For Students and Practitioners of Medicine. By Forrest Ramon Davison, Ph.D. 4th Edition. 730 pages, with 35 illustrations, including 4 in color. Cloth. Price $8.50. The C. V. Mosby Co., St. Louis, 1949.

This Handbook in its opening pages attracts one's attention by the very concise and complete explanation of the basic principles of Pharmacology. This includes the derivations and meanings of the terms used in the study of drugs and their uses in an easily understandable manner. The subject is built up gradually and correlates the basic sciences and clinical medicine without extensive reading of unnecessary and long, difficult data. For example, in "Methods of Drug Administration," each method is explained clearly and most completely with only the salient facts included. I agree with the author that drugs have taken such a fast and furious stride that it is impossible to keep up with all preparations and that we may lose sight of the fact that we still have many tried and true preparations in the U.S.P., N.F., and N.N.R. that are valuable. The same short and concise method carries through the Materia Medica and Prescription writing chapters, which give anyone a rather complete basic knowledge of those subjects.

Chapter IV on Toxicology is most complete and practical. The grouping of the drugs according to their activities are especially good. Each one has a short history and description, pharmacological action, toxicology, therapeutic uses and method of administration which attracts the interest and is easy to read.

The many diagrams and illustrations given help greatly to clarify the actual parts and locations of the body affected by the drugs as they are described. The final chapters on blood and biologicals are easy reading and give much valuable information.

In conclusion, I would say that this book is excellent. It can fill a very important position in aiding all doctors in understanding and being able to use information obtained from various sources in a more practical way for the better treatment of their patients.

C. H. R.

?

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A YEAR WITH OSLER. By Joseph H. Pratt, a member of the class of 1898. 209 pages, with 6 illustrations. Price $4.00. The Johns Hopkins Press, Baltimore, 1949.

This is a delightful book for medical intellectual browsing. Osler's reputation and his impress upon medical thought and teaching were so universal that any **Medicinae Doctor** ought to be pleasantly stimulated by these intimate glimpses of Osler through the eyes and ears of one of his students. It is at once apparent that most of the notes are essentially verbatim accounts of Osler's teaching and thus "bottled in bond."

It is difficult for us to realize the changes in types of disease commonly seen in medical practice over a span of fifty years. Typhoid fever and pneumonia were the most numerous. Syphilis also appeared with great frequency and in many forms which are common no longer. The complications arising in these three diseases alone gave Osler opportunity to cover many other subjects in the differential diagnosis. On the other hand, many less common diseases were encountered, including Addison's disease, with a note, in May 1897, of improvement on adrenal extract! Many of the "Amphitheatre Clinics" are early models of the modern C.P.C.

But aside from all this, there is much for the present-day practitioner to learn from these Clinics of 53 years ago. While they employed many tests and methods we have now, such as blood counts, bacteriological cultures, and malaria smears in diagnosis, the chief reliance was still upon accurate, detailed clinical observation ably correlated with a very large fund of clinical knowledge. One is impressed, as he reads, by the clear confidence these men had in the results of their deductions based on the method described above. And most of the time they were correct. The pleasure in reading this book was emphasized at the beginning of this review, yet the reader will experience some pangs of regret and conscience as he realizes how he has gradually, since his student days, allowed so much of his thinking to be done for him by technicians, radiologists, **et alii.** Such "pangs," however, are soon relieved by a dose of pride in the accomplishments of modern medicine, since one of the most salient features of the entire book is not in the text at all, but lies between the lines,—namely, the comparative helplessness of those giants of old when it came to treatment. Transfusions were rare, antibiotics unheard of, and surgery was just entering into adolescence. Yes, we can be proud, yet humble in the same breath, for we feel that, barring some terrible collapse of civilization, the next fifty years will see progress equal to the last fifty. We still see cancer, tuberculosis, leprosy and many others,—do we not?

—A. W. C.

TONICS AND SEDATIVES. By Morris Fishbein, M.D., Editor of *The Journal of the American Medical Association.* 120 pages. Cloth. Price $2.00. 51 original drawings. J. B. Lippincott Company, East Washington Square, Philadelphia.

Anyone who has read the perennial "Tonics and Sedatives" column in *The Journal of the American Medical Association* any time during the past thirty-five years (and who in the medical profession has not?) will know what to expect of this little volume. The fact that the contents represent the careful selection by Doctor Fishbein from what must be the world's greatest gold mine of medical jokes, puns, limericks, boners and what-have-you in the way of the rare and entertaining, should be enough encouragement for any right-minded medico to want a copy for his bedside table, if not for his waiting room, as well. Many have clipped the items from their discarded *Journals* and made their own file of the "Ts. & Ss." but no one could be quite as discriminating as Doctor Fishbein, nor does anyone have his vast file of material that supplied him with the text for this book. So this appears to be an obvious MUST for the members of the medical profession who want a laugh, and who of us do not?

FOR THE NEW MOTHER. By Mildred V. Hardcastle, R.N. 163 pages. Price $2.00. The John C. Winston Company, Philadelphia, 1949.

This is an easy-to-read, easy-to-understand handbook for the new mother. The author must have been initiated "the hard way," having had twins, herself, and her book is written with both sympathy and insight. It is also exceedingly sensible and should be acceptable from the physician's standpoint.

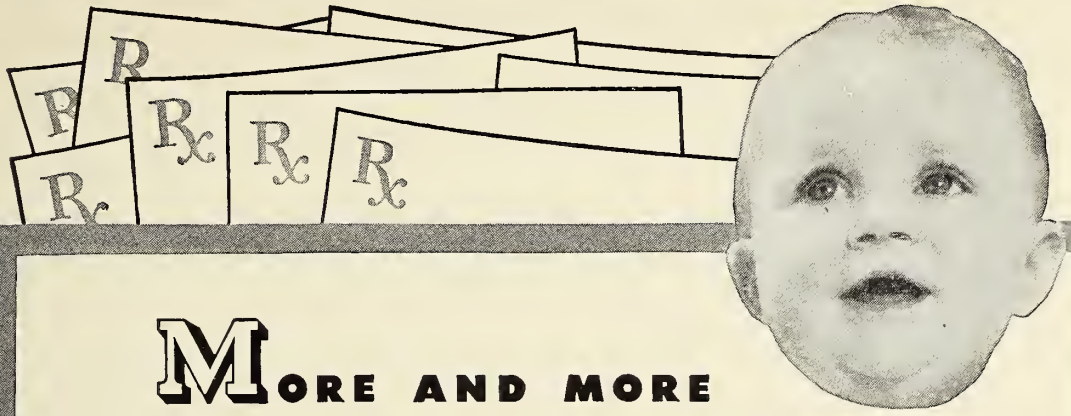
Chapter One begins with the day baby and mother come home from the hospital and is entitled "Easing into a Schedule." This title gives the clue to the most valuable feature of this book, namely, the cultivation and practice of equanimity. All through the volume the mother is advised, urged or cajoled to "ease into" each new demand on her time and energy, and to ease the baby into each new phase of his progress during his entire first twelve months.

Instructions in methods and technique such as making formula, baby's bath, and first aid for emergencies are clear, simple and accurate. Furthermore, the point at which home remedies do not suffice and the doctor should be called is indicated with sufficient emphasis. "Safety first" is another theme which runs through the entire book, and if all of the sensible precautions therein described were carried out by all mothers, babies would have few accidents, indeed.

Of unusual interest is the rather detailed attention to the personality of the baby and to that of its mother. This is handled delicately but vigorously and should prove very helpful, since the psychological side of an infant is a mystery to many,—especially to one who has herself been reared in a small family. The index is a thoughtful provision and seems sufficient. A. W. C.

AN ATLAS OF THE BLOOD AND BONE MARROW. By R. Philip Custer, M.D., director, Laboratories of the Presbyterian Hospital in Philadelphia. 321 pages with 285 figures, 42 in color. Price $15.00. W. B. Saunders Company, Philadelphia, 1949.

This excellent volume fills a long-recognized need for a useable book on bone marrow. Prior to Dr. Custer's work, the books on bone marrow were too inadequately illustrated to be of any real value. In contrast to those of the past with their drawings or inadequate photographs, this book is beautifully illustrated with an unusual number of photomicrographs, many of which are in color. The author discusses every blood dyscrasia particularly from the standpoint of accuracy of diagnosis. The value of paraffin sections of bone marrow is strongly urged. A short chapter on the technic of bone marrow aspiration is included. This book will probably not be attractive to the general practitioner, but to the hematologist and clinical pathologist it will be a most welcome addition to his library.



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FUNDAMENTALS OF OTOLARYNGOLOGY. A Textbook of Ear, Nose and Throat Diseases. By Lawrence R. Boies, M.D., Clinical Professor of Otolaryngology, Director of Division of Otolaryngology, University of Minnesota Medical School, and Associates. 443 pages with 184 figures. Price $6.50. W. B. Saunders Company, Philadelphia, 1949.

This is a departure from the usual musty type of antiquated historal textbook information.

As Doctor Boies states in his preface, "We believe it represents the opinion of today that has a factual basis."

This makes it especially valuable to the student and general practitioner, who get concise, practical information without poring over all the mistakes made since 1890.

However, the busy otolaryngologist, who has not had time to review all the literature on the newer, commoner office procedures and treatments, will find that Doctor Boies and his associates have done an excellent piece of work for him.

The reviewer enjoyed every chapter of this book.

R. F. C.

YOUR CHILD MAKES SENSE. A Guidebook for Parents. By Edith Buxbaum, Ph.D. 204 pages. Cloth. Price $3.25. International Universities Press, 227 West 13th Street, New York 11, New York.

The first chapter is written by Florence L. Swanson, M.D., who gives us practical knowledge of babies and the answers to many questions which our little patients' parents put to the doctor.

The remainder of the chapters are by Dr. Buxbaum and deal with child psychology and how it applies to many of the perplexing problems with which the practitioner is faced.

Most of the points and problems presented are illustrated by cases which the author has handled. The psychological problems presented and their solutions are, on the whole, too complex for this to serve as a guidebook for most parents. However, it is a rich source of practical information on child psychology for doctors and other professional workers who deal with children, for she explains the handling of such problems as thumb-sucking, cursing, disobedient children, bladder control, and bedwetting, sexual awareness in children, the value of nursery schools, kindergarten and the like.

D. M. J.

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—SEPTEMBER, 1949

Disease	Sept. 1949	Aug. 1949	July 1949	Sept. 1948	Sept. 1947
Brucellosis	7	5	5	5	6
Chickenpox	8	11	30	19	12
Infectious diarrhea	1	0	0	0	0
Diphtheria	55	39	32	13	17
Encephalitis	5	3	5	4	8
Erysipelas	1	0	3	2	0
Food poisoning,					
shigella	5	2	3	0	0
Enteritis	1	0	0	0	0
Impetigo	10	0	3	6	11
Influenza	4	37	13	16	53
Jaundice, infectious	1	1	0	0	0
Measles	24	39	169	9	11
Meningitis,					
Meningococcic	1	1	2	1	0
Lymphocytic chorea	1	0	0	0	0
Unclassified	1	2	2	3	4
Mumps	9	14	65	21	9
Paratyphoid fever	1	1	0	2	2
Pneumonia	19	38	10	29	27
Poliomyelitis,					
Paralytic	78	130	128	90	38
Nonparalytic	30	70	54	38	58
Unspecified	130	150	74	9	0
Rabies in animals	17	47	69	31	--
Rheumatic fever	1	1	1	1	0
Rocky Mt. spotted fever	1	0	4	3	1
Scarlet fever	32	20	25	49	50
Tetanus	2	0	2	1	2
Tinea capitis	5	0	1	2	6
Tuberculosis,					
Pulmonary	130	168	204	237	225
Other forms	18	15	18	20	9
Tularemia	1	0	0	0	2
Typhoid fever	3	4	8	10	18
Vincent's Angina	1	0	1	0	0
Whooping Cough	73	66	116	56	170
Dysentery, bacillary	6	1	6	0	1

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—OCTOBER, 1949

Diseases	Oct. 1949	Sept. 1949	Aug. 1949	Oct. 1948	Oct. 1947
Brucellosis	5	7	5	6	10
Chickenpox	72	8	11	80	95
Diarrhea, infectious	1	1	0	0	0
Diphtheria	34	55	39	47	43
Dysentery, amoebic	1	0	0	0	2
Erysipelas	1	1	0	0	2
Food infection,					
Unspecified	4	0	2	0	0
Salmonellosis	1	0	0	0	0
Impetigo	3	10	0	0	13
Influenza	18	4	37	16	46
Measles	87	24	39	19	24
Meningitis,					
Unclassified	4	1	2	1	5
Meningococcal	5	1	1	5	1
Tuberculosis	1	0	0	0	0
Mumps	42	9	14	67	19
Paratyphoid	1	1	1	0	2
Pneumonia	21	19	38	49	48
Poliomyelitis,					
Paralytic	45	78	130	38	29
Nonparalytic	22	30	70	13	13
Unspecified	125	130	150	14	0
Rabies in animals	59	17	47	43	14
Rubella	11	0	2	1	6
Scarlet fever	77	32	20	110	109
Septic sore throat	5	0	30	0	10
Tetanus	2	2	0	0	1
Tinea capitis	28	5	0	6	65
Tuberculosis,					
Pulmonary	219	130	168	165	171
Other forms	14	18	15	5	10
Typhoid fever	3	3	4	11	3
Vincent's angina	7	1	0	0	5
Whooping cough	88	73	66	35	175
Encephalitis	3	5	3	4	2

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PREVENTION PREFERRED IN THE OPERATING ROOM*

R. J. WHITACRE, M.D., AND NICHOLAS DEPIERO, M.D.

CLEVELAND

Dr. Whitacre

The Authors:

Doctor Whitacre is director of the Department of Anesthesiology, Huron Road Hospital, in Cleveland. He is a graduate of the Hahnemann Medical College in 1933. He is president of the American Society of Anesthesiologists, and a member of the Board of Directors of the American Board of Anesthesiology.

Doctor DePiero is a 1942 graduate of the Hahnemann Medical College, and is a member of the American Society of Anesthesiologists. He is a member of the Department of Anesthesiology, Huron Road Hospital, Cleveland.

Dr. DePiero

EMERGENCY measures have repeatedly proved their lifesaving value in the operating room, but for overall results preventive measures and precise care are much to be preferred to spectacular rescues. The routine institution of known preventive measures in the operating room will decrease the need for heroic resuscitative efforts on the part of the operating team. This will not only increase the survival rate but it will also speed the physiologic rehabilitation of the patient.

It has been estimated that in the United States about 10 million operations are performed in a year, and practically no organ, system or age bracket is exempt. Mortality and morbidity rates that were quite acceptable even a few years ago will and should be more critically evaluated as even larger numbers of patients submit themselves to surgical care in the future. In the past it was not uncommon to have surgical mortality rates of 1 in 1,000.[1] When such a rate is applied to 10 million operations it amounts to the appalling figure of 10,000 deaths each year. On the basis of preliminary reports being made by such bodies as the Philadelphia Anesthesia Study Commission[2] approximately 50 percent of the deaths investigated are considered to have been preventable.

* Presented at the centennial session of the Indiana State Medical Association at Indianapolis, September 27, 1949.

When this problem is viewed from a nation-wide experience rather than from the experience of the individual surgeon, it suddenly becomes more significant. The answer lies in the routine institution of preventive measures during surgery.

For the anesthesiologist the practice of preventive measures actually begins with preoperative rounds. At this time he has the opportunity to evaluate the patient and to order the premedication. The mental tranquillity which the patient gains from reassurance, explanations, and answers to his questions regarding the anesthesia in no small measure contributes to a successful anesthesia and a satisfied patient. Premedication to suit individual requirements is important to provide proper sedation, but in addition it often widens the margin of safety by depressing reflexes and making it possible to use less of the anesthetic drugs.

OXYGENATION AND HYPOXIA

The greatest and most frequently occurring hazard to which a patient is exposed during surgery is a lack of oxygen. Anoxia is that quiet stealer of life that repeatedly snatches its victim in the operating room in the very presence of expert witnesses. Yet frequently the surgeon and even the anesthesiologist do not recognize when hypoxia first appears. When it is recognized it is often far advanced and circumstances are such that it cannot be corrected until some degree of damage has occurred. The complexity of this problem is deceptive. Once we recognize that preventing anoxia is a complicated problem of major importance, we have taken the first step in preventing deaths during surgery.

In the operating room the first consideration is to have resuscitative equipment immediately available and in good working order. This is an elementary precaution which is too often neglected, with disastrous results. Furthermore, the time to adjust and test the machine is before the patient enters the operating room and not when an emergency must be met.

When oxygen is supplied to the patient it often fails to reach the lungs because of respiratory obstruction. In selected cases it may be advisable to assure the patency of the airway by inserting an endotracheal tube before the anesthesia is started. As a preventive measure this is particularly indicated where there is danger of aspiration of stomach contents, as in cases of intestinal obstruction with repeated vomiting. The presence of preoperative respiratory obstruction or inflammatory lesions of the neck such as Ludwig's angina may constitute additional indications for this procedure.

Insertion of the endotracheal tube while the patient is still awake can be accomplished under topical anesthesia. The transtracheal injection of 4 to 6 cc. of 4 percent cocaine directly into the trachea through the cricothyroid membrane is an effective means of anesthetizing the larynx.

Occasionally the point of obstruction is in the lower respiratory tract. It may be caused by aspirated foreign material or by pulmonary edema. When this occurs an immediate tracheobronchial toilet is indicated. The frequent neglect of such intervention, particularly in obstetrical patients who are prone to aspirate vomitus, courts the danger of pulmonary complications. Obstruction to pulmonary ventilation may also be due to reflex spasm of the bronchial and respiratory muscles. This occurs most often when the anesthesia is too light.

It is not always easy to determine how much oxygen the patient is receiving. Gas machines in use at the present time do not accurately provide this information and we must of necessity rely heavily on clinical judgment to determine whether a patient is adequately oxygenated. A real aid is the simple but often neglected practice of administering an excess of oxygen at all times. The partial pressure of oxygen must be adjusted to the minute volume exchange. An oxygen concentration of 20 percent may be adequate with normal respiration, but if respiratory activity is depressed a compensatory increase in the concentration of oxygen in the inhaled atmosphere will be required. Therefore, arbitrary statements about the proper concentration of oxygen, without considering rate and depth of respiration, may be misleading.

Maintaining an adequate minute volume respiratory exchange has become a problem of pressing importance since the advent of anesthetic agents which act as depressants of the respiratory center. With the extending employment of pentothal, cyclopropane, curare and spinal anesthesia it has become increasingly difficult to detect and prevent respiratory depression. Compensated or controlled respiration should be utilized whenever necessary to effect a proper pulmonary exchange of oxygen and carbon dioxide.

Certain positions necessitated by the character of the operation have a profound effect on the minute volume respiratory exchange. Kidney rests, gallbladder lifts, sandbags and similar surgical aids often embarrass respiratory activity. The prone position or head-down position will reduce the vital capacity about 15 to 20 percent. In these positions the diaphragm is forced cephalad. There is an actual reduction of respiratory space and a partial collapse of the lungs which interfere with oxygenation of the blood. The patient is also required to exert a greater respiratory effort to move the weight of the abdominal viscera or the body during each inspiration. The normal patient can easily compensate for this embarrassment but in the presence of cardiac deficiency, circulatory failure may quickly ensue. The careless application of drugs and positions that depress respiration must be constantly guarded against to avoid anoxia. This is sometimes difficult because the demand for both is constantly increasing.

Cyanosis is a time-honored guide in recognizing oxygen deficiency. It is important to recognize,

however, that a patient may be hypoxic without being cyanotic. Furthermore, it is a sign not too easy to perceive or evaluate correctly. In an experiment conducted by Comroe and Botelho,[3] in which varying concentrations of oxygen were administered to patients, observers were unable consistently to detect the presence of cyanosis until the arterial oxygen saturation fell to a dangerously low point. These investigators found that visual impressions even under the best lighting conditions are by no means reliable. Consider then the actual operating room conditions where poor lighting and drapes will rob this sign of even more of its significance. We do not wish to minimize the importance of cyanosis when it occurs but a patient may be suffering from oxygen lack before cyanosis is evident. For instance, in shock the peripheral vasoconstriction will cause pallor and prevent cyanosis from showing though the blood may be very much underoxygenated. Again, if the hemoglobin is low, cyanosis may not even be evident since its appearance is dependent upon a definite quantity of reduced hemoglobin. Until practicable instruments are available which will continuously record the oxygen content of the blood, prevention by administering excess oxygen at all times is our chief means of defense. The realization that we daily fall short of attaining this goal of adequate oxygenation should materially hasten the routine application of this prophylactic measure.

The brain is especially vulnerable to oxygen lack. It has been shown[4] that loss of consciousness occurs in less than seven seconds after arrest of cerebral circulation. Serious damage to the brain may occur in a very short time when the oxygen supply to this organ is completely cut off. This helps to explain why death can occur with such rapidity due to an overdose of a spinal or intravenous anesthetic. Here there may be a simultaneous circulatory and respiratory failure which effectively arrests the oxygen supply to the brain.

Brain damage may occur without either circulatory or respiratory depression. This can be due to an increased cellular demand for oxygen or the inability of the brain tissues to utilize the available circulating oxygen. The first indication may be the occurrence of a convulsion during the anesthesia. Convulsions during general anesthesia are serious complications because they often represent irreversible damage to the brain.

Conditions which predispose to anesthetic convulsions are those making high metabolic demands, such as acute infections and high body temperatures. For the same reason convulsions occur more frequently in children and young adults. The danger is increased when the humidity and temperature in the operating room are high. Under such circumstances it is advisable to use regional or local anesthesia because deep inhalation anesthesia may be a precipitating factor.

Drugs such as atropine, which favor the retention of body heat by inhibiting perspiration, should be avoided. Cold packs may aid in controlling body temperature, thereby reducing the tissue demand for oxygen.

Convulsions during anesthesia can be prevented in most instances by controlling the various factors which interfere with oxygenation of the brain.

REFLEXES

Reflexes are important protective mechanisms of the body, but during anesthesia they often are a source of annoyance to the surgeon and the anesthesiologist. At times they may even prove dangerous to the patient.

The problem of reflexes during surgery has been accentuated during recent years owing to the increased use of drugs such as pentothal and cyclopropane, which often depress respiration without abolishing reflex activity. With active reflexes surgical stimulation may produce a spasm of the muscles of respiration or cause cardiac irregularities.

The occurrence of a laryngospasm during an abdominal operation is a common example. The effect of such spasm is to push the intestines into the operative field and tighten the abdominal muscles, making it difficult for the surgeon to proceed. At the same time the patient becomes progressively hypoxic due to the respiratory obstruction or breath-holding. Sudden cardiac arrest has occurred from pressure on the eyeballs or traction on the hilus of the lung. Prevention lies in anesthesia of a depth adequate to abolish reflexes. Occasionally the necessary depth of general anesthesia cannot be accomplished without jeopardizing the life of the patient. Here the use of regional or local anesthesia can often be used to block reflex responses; or the judicious use of curare may accomplish this purpose.

It is in the control of reflex activity that the widening practice of balanced anesthesia finds a fruitful field of application. Experience has demonstrated that it is often much safer to use a combination of two or more agents or methods to provide adequate anesthesia. The use of nitrous oxide and curare with pentothal, or cyclopropane and ether with spinal anesthesia, will make it possible to utilize much smaller doses of the intravenous or spinal anesthetic. This is a very important means of increasing the safety of these two methods of anesthesia. There are numerous other combinations of drugs and technics which, if skillfully blended, will avoid the dangers of large doses of a single agent.

At the other extreme, anesthesia may be too deep and so endanger the life of the patient. A tracheal tug or gasping type of respiration may mean that a progressive paralysis of the intercostal muscles is taking place, due to increasing depth of anesthesia. The exaggerated activity of the diaphragm may erroneously be considered as evidence that deeper anesthesia is required, where-

as the proper course is to lighten the anesthesia, administer oxygen and allow a few minutes for the patient to eliminate excess carbon dioxide.

Both the surgeon and anesthesiologist are interested primarily in their own problems. When these overlap a mutual respect and a nice degree of cooperation will do much to simplify the work of both. This invariably accrues to the benefit of the patient.

HEART AND CIRCULATION

Supportive therapy has become such a common practice that we no longer wait for signs of shock to appear before starting intravenous fluids. The early signs of circulatory failure are often deceptive and difficult to evaluate. Experience has shown that we cannot rely entirely upon the blood pressure and pulse readings to indicate the onset of surgical shock. To be sure, these signs should be carefully watched, but they do not immediately reflect the results of trauma and blood loss.

A compensatory vasoconstriction may maintain the blood pressure until the mechanism breaks down and the typical picture of oligemic collapse is presented. In selected cases, such as intestinal resections or thoracic operations, where shock and hemorrhage are anticipated, blood transfusions are necessary from the beginning of the operation.

When administering blood a 15-gauge needle will permit a rate of flow more than twice that through an 18-gauge, and five times that through a 20-gauge[5] needle, providing the veins are not collapsed. If, however, the veins are contracted due to shock, pressure must be used even with a large needle to effect rapid blood replacement.[6] Equipment can readily be devised by which positive pressure can be supplied by a blood pressure bulb. Such apparatus should be available for prompt use in all institutions.

In the operating room a rapid pulse rate has always indicated danger but a slow rate is usually disregarded. Actually, a slowing of the heart may be of equal significance. A decrease in pulse rate to 60 or less may signify hypoxia or excess vagal stimulation. If the bradycardia is not relieved by the administration of more oxygen, 1/300 gr. (0.22 mg.) of atropine intravenously will often increase the heart rate and improve the cardiac output. We have frequently noted that a small amount of atropine not only increases the heart rate but often elevates the blood pressure and improves the circulation.

Certain arrhythmias may lead to the more serious condition of ventricular fibrillation. Decreasing the irritability of the heart by the proper use of intravenous procaine or the timely cessation of mechanical stimulation may readily avert more serious complications. These prophylactic measures are especially valuable during thoracic surgery. Ouabain, a drug to which we should like to call particular attention, can occasionally be used to advantage in the operating room. A fall in blood pressure, with a marked decrease in pulse pressure that does not respond to replacement therapy, may indicate a failing myocardium, hence a need for ouabain.

It has been our experience that occasionally more than one person is required to provide proper care to the patient during anesthesia. Maintaining an airway and adequate pulmonary ventilation, administering fluids and drugs, evaluating accurately the cardiac and respiratory status, recognizing the signs of oxygen lack or carbon dioxide excess, and instituting corrective measures at the proper time, are often more than one person can possibly deal with alone, particularly when several demand attention at the same time. We are positive that timely assistance and advice have prevented many complications in our operating rooms which might otherwise have jeopardized the patient's life. In the final analysis, the judgment and skill with which the anesthetic drugs and technics are applied are the deciding factors in determining the safety of anesthesia. It is evident that there are many more deaths in the operating room than is generally appreciated.

CONCLUSIONS

Prevention of complications during surgery is the avenue by which safety in the operating room can be greatly increased in the future. By anticipating complications and by constant vigilance during surgery, much can be done to reduce the number of operating room casualties.

This problem is being approached in another direction. A resolution adopted by the House of Delegates of the American Medical Association in June, 1949, provides that machinery be set up and funds allocated for the collection and recording of information concerning operating room deaths on a nation-wide basis. It is our hope that this study will materially aid in the prevention of operating room fatalities in the future.

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THE PRESENT STATUS OF THE FENESTRATION OPERATION IN THE TREATMENT OF DEAFNESS DUE TO OTOSCLEROSIS*

Ralph J. McQuiston, M.D.**

Indianapolis

The Author:

Doctor McQuiston received an A.B. degree from Franklin College in 1928, an M.D. degree from Indiana University School of Medicine in 1932. He served an internship and was resident in otolaryngology at the Indianapolis General Hospital, and was resident in otolaryngology at the Indiana University Medical Center. He was associated with the Lempert Institute of Otology for fenestration surgery and the Foman Clinic for plastic surgery in New York. During the war he served in the Army Air Forces. He is a diplomate of the American Board of Otolaryngology, a member of the American Academy of Ophthalmology and Otolaryngology, and the American Laryngological, Rhinological and Otological Societies.

THE conservation of hearing presents a major problem for the medical profession. Hearing is one of the most important avenues of learning, and its conservation is of the utmost importance in public education and public health. It is now estimated that from 5 to 6 percent of the total population of this country suffers from some degree of hearing loss. The economic loss from this handicap and the loss of human happiness in this group of individuals is beyond determination.

The majority of cases of deafness result from middle ear infections, mastoid infections, and the involvement of the auditory nerve, which complicates such communicable diseases as scarlet fever, measles, mumps, meningitis, influenza, colds, sinusitis and infections of the tonsils and adenoids. These types of deafness may be prevented to a large degree by controlling the communicable diseases by preventive medicine. However, the medical profession has long realized the futility of its efforts to prevent deafness due to otosclerosis. This type of deafness has been known to doctors for more than seventy-five years, but the cause of this condition remains unknown. Infections of the upper respiratory tract and the communicable diseases have nothing to do with its development or its progress.

THE CHARACTERISTICS OF OTOSCLEROSIS[1]

1. The deafness is a bilateral, slowly progressive, conductive type. It usually starts at about the age of puberty and by the time the patient has reached the late twenties or thirties the hearing loss amounts to a serious handicap to the individual. This type of deafness occurs more frequently in the female and becomes worse with pregnancies.

2. Tinnitus may be one of the symptoms and it may be noticed before the patient is conscious of any hearing loss. This sensation of noise in the ears may be felt in one or both ears and can range from a high-pitched note to a low tone. At times these head noises are very distressing to the individual.

3. Paracusia Willisii is the sensation of hearing better in noisy places. This is noticed particularly by those who work in the presence of constant noises. It provides a good clinical sign of fixation of the stapes. The normal individual's stapes will be pushed inward to protect the labyrinth in the presence of noises and he will not hear so well. However, the otosclerotic patient's stapes is fixed and his hearing is not changed, so relatively they may hear better than the normal hearing person in the presence of noises.

4. Vertigo or slight dizziness may be experienced upon sudden changes of position. This is not a constant symptom, but if vertigo becomes a predominating symptom it is probably evidence that the cochlea itself is becoming involved by the otosclerotic lesion.

5. The eardrum itself is essentially normal. It may appear thin, translucent and atrophic. Many textbooks describe a pinkish hue of the promontory which may be seen through the thin, clear eardrum. However, this is seen in only a small percentage of the cases and it is the otosclerotic lesion itself which has become

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** From the Department of Otorhinolaryngology, Indiana University School of Medicine.

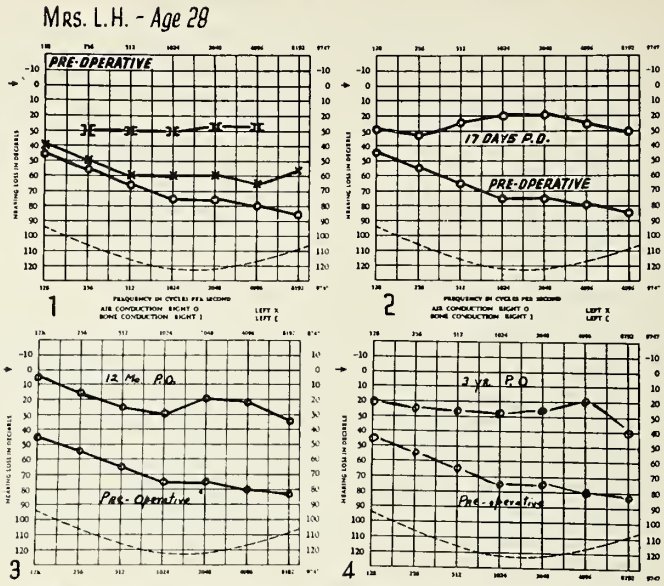
superficial upon the promontory of the cochlea. When seen, this finding is pathognomonic of otosclerosis.

6. Otosclerosis has a tendency to run in families; however, many members may actually have this condition and have no symptoms. If the otosclerotic lesion does not involve the region of the oval window, resulting in fixation of the stapes, it may not cause deafness and the diagnosis could not be made.

The lesion of otosclerosis is a sharply-defined, bony tumor occurring endochondrally within the otitic capsule. It occurs most frequently in the region of the oval window; however, it also has been found involving areas about the round window, cochlear capsule, and the fundus of the internal auditory canal. If this bony growth proliferates endosteally or periosteally in the region of the oval window, it will cause the stapes to become immobilized and the symptoms of otosclerosis will be produced. This bony tumor is benign and it never metastasizes to any other part of the body and causes no symptoms except those ear symptoms described.

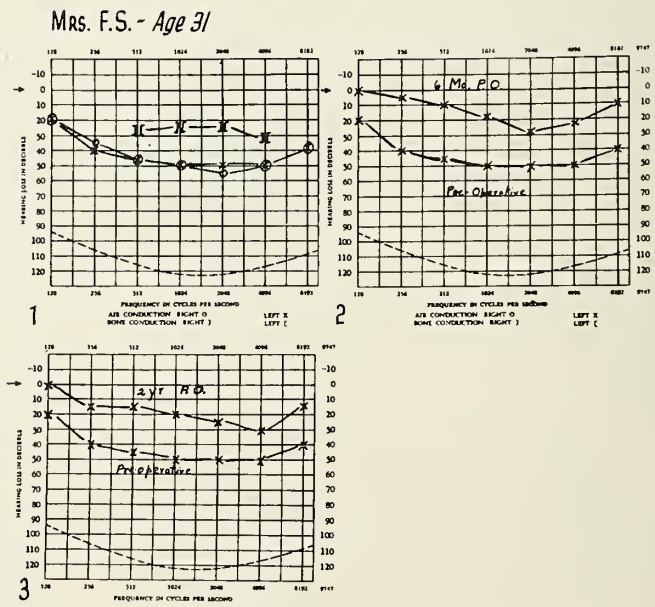
Throughout the years many forms of treatment have been employed to prevent and cure deafness due to otosclerosis. Drugs, diets, vitamins and other local or systemic therapies have proved worthless. The idea of the fenestration operation was conceived more than seventy-five years ago when an otosclerotically deafened individual suffered a skull fracture. The fracture involved the temporal bone in the region of the labyrinth, creating a new opening, and thus restoring his hearing. Following this observation many attempts were made to devise an operative procedure to create a new opening into the labyrinth to restore hearing in these individuals. The early surgical procedures were very complex and often required three or four-stage operations and many hours

Fig. 1. Audiograms of Mrs. L. H. Age 28.



This patient's preoperative audiogram revealed a 60 to 75 decibel loss for air conduction in the speech frequencies, while the bone conduction showed the cochlear nerve function to be capable of receiving these frequencies at the 30 decibel level. The right ear was operated and subsequent audiograms reveal that normal hearing was restored for the speech frequencies and has been maintained for three years. This result is considered permanent.

Fig. 2. Audiograms of Mrs. F. S. Age 31.



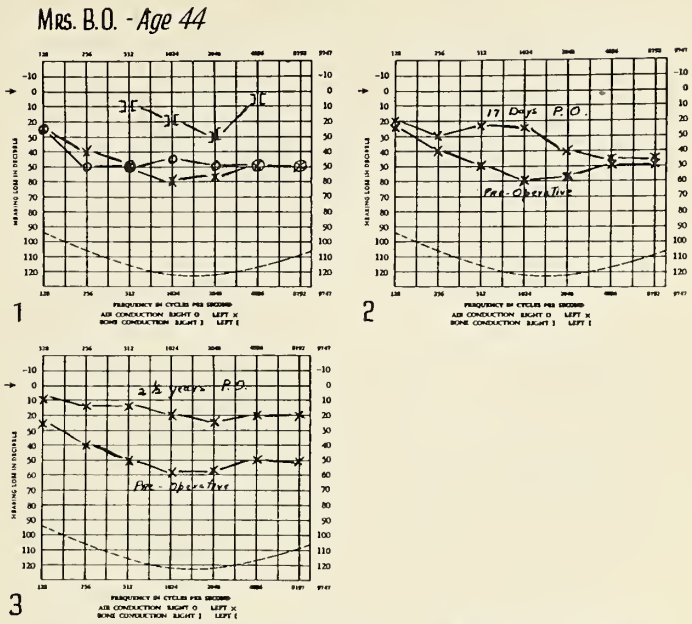
Following fenestration there is a 30 decibel improvement of hearing for the speech frequencies, resulting in normal hearing for the conversational tones. This improvement has been maintained for 2 years and is now considered permanent.

to accomplish. These surgical procedures originated with the work of Holmgrem of Sweden in 1916 and later by Sourdille of France in 1924. However, it was not until Lempert[1] presented his fenestration technique in 1938 that a practical one-stage operation was devised. This technique consists of creating a new window or fenestra into the labyrinth to replace the oval window which has become closed by the otosclerotic lesion, thus forming a new conductive route by which sound waves are permitted to reach the auditory nerve and restore hearing. This new fenestra is covered and protected by a portion of the eardrum or skin of the adjacent external auditory canal, which acts as a vibrating membrane.

Theory of the fenestration operation is based on the belief that to have normal hearing there must be two functioning windows into the labyrinth, one into the vestibular portion and one into the cochlear portion, in order to have the perilymph mobilized by air-borne sounds, permitting them to reach and stimulate the auditory nerve. If one of these openings becomes sealed up, as in the case of otosclerosis closing the oval window, the perilymph cannot be mobilized and the sounds do not reach the nerve of hearing.

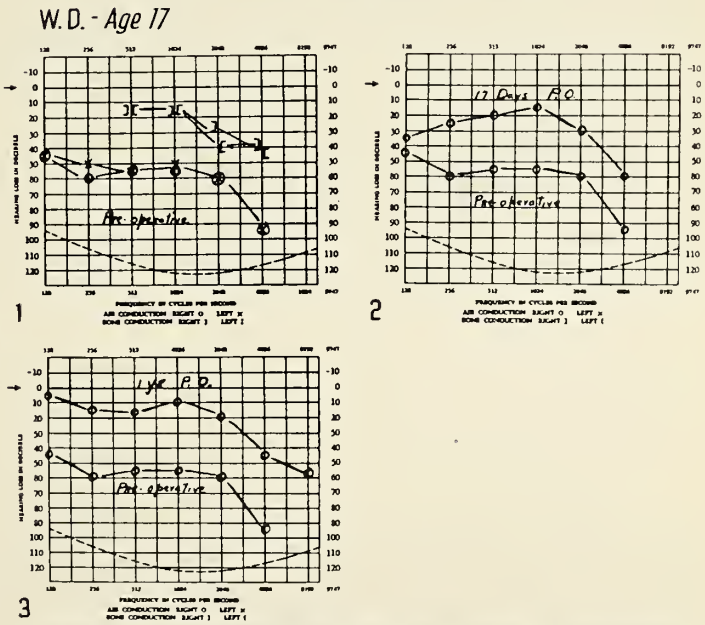
After the diagnosis of otosclerosis has been established the otologist must determine if the individual is a suitable candidate for fenestration surgery. In general the eardrum must be intact and the auditory nerve must be capable of receiving and transmitting the conversational tones to the auditory center in the brain. This reserve auditory nerve function, which is not being used, can be determined by tuning fork tests and audiometric readings. If found to be capable of receiving the conversational tones, which are the 512, 1024 and 2048 sound vibrations, at the 30 decibel or above, the patient is considered a suitable case for the fenestration operation.[2] As a rule the younger age groups have better results following surgery. As the deafness resulting from this condition is first noticed

Fig. 3. Audiograms of Mrs. B. O. Age 44.



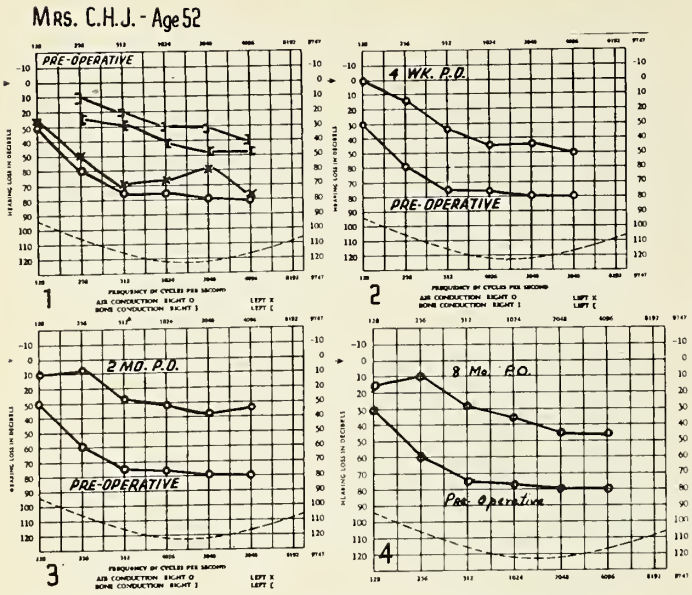
This patient's audiograms reveal a 40 decibel improvement in hearing for the speech frequencies following fenestration resulting in normal hearing for the spoken voice. This result has been maintained for 2½ years and is now considered permanent.

Fig. 4. Audiogram of Miss W. D. Age 17.



Following the fenestration operation there is a 40 decibel improvement in hearing throughout the speech frequencies. This improvement has remained constant for 1 year; however, this result is not yet considered permanent.

Fig. 5. Audiograms of Mrs. C. H. J. Age 52.



Following fenestration the audiograms reveal a 30 decibel improvement in hearing for the speech frequencies. Regardless of the improvement this result is not considered good, because two of the three conversational frequencies fall below the 30 decibel level. This patient will still have difficulty in hearing the normal spoken voice.

in the late teens and is gradually progressive, when the individual is in his late twenties or early thirties he is in need of some form of hearing aid in order to lead a normal life. This age group has shown the best results following fenestration. While those in their late forties and fifties may have excellent results, they are not generally considered to be as good candidates as those in the younger age bracket.

The accompanying audiograms illustrate the hearing improvement following the fenestration operation. This improvement should be maintained on or above the 30 decibel loss level for the vibrations 512, 1024, and 2048, if the patient is to have normal hearing for the conversational tones.

In these audiograms these signs are used:

Bone Conduction
]—Right ear
[—Left ear

Bone Conduction
O—Right ear
X—Left ear

The results in the fenestration operation for relief of deafness due to otosclerosis compare favorably with other types of major surgery in other fields. From statistics now available it is found that 80 percent of those suitable cases operated will have restoration of hearing in the first few weeks following surgery. During the first year this may drop to 70 percent and during the second year it may drop further to 60 or 65 percent. However, after two years that result is generally considered as permanent.[3] The cause of the loss of hearing after it has once been reestablished in most cases is due to bony closure of the fenestra. Considerable research has been and is being conducted in an effort to reduce the number of bony closures. To date the fenestra[1] has been moved farther forward to the dome of the vestibule where the bone is thinnest and a larger fenestra can be made; more periosteal bone has been removed around the opening,[3] and gold and lead burnishing burrs[1] have been used in an effort to prevent the development of new bone which closes the fenestra. These changes have been improvements, but none of these efforts have proved infallible. Another cause of failure in the operation is a labyrinthitis which may develop in the first few days postoperatively or up to two or three weeks; however this usually subsides and the hearing returns to normal in most cases. Since the routine postoperative use of penicillin, the incidence of labyrinthitis occurs in less than 1 percent of the cases.

The fenestration operation is probably the most delicate and exacting operation performed today. Each step must be carried out expertly if the patient's hearing is to be restored. In order to accomplish this the surgeon must have special training in this type of surgery.[4] He must acquire the refinements in his operative technique necessary for handling the delicate structures encountered. He must get accustomed to working under magnification and using the motor driven drill. This requires considerable practice on the cadaver before the operation is performed on a patient. Fortunately serious complications following this operation are rare.[2] These complications include labyrinthine damage, facial nerve paralysis, meningitis, and so forth. To date no deaths have been reported which are directly attributed to the surgery. The postoperative course is usually uneventful. The patient may experience some vertigo and nausea for the first two or three days, then as a rule these symptoms subside and the patient is able to be out of bed on the fourth postoperative day. The packing is entirely removed on the fifth day and the patient may go home on the eighth or ninth postoperative day.

Today the patient with otosclerosis has but one of two choices when his hearing loss reaches the stage where he must have help. One is the fenestration operation, and the other is the hearing aid.

Early in this type of deafness the hearing aid gives satisfactory results, but it does have its limitations. It does not prevent the progress of the condition and nerve deterioration may continue until the hearing aid becomes of little or no value. It has been found that in a successfully fenestrated patient the nerve function seems to remain at the preoperative level, while in the unoperated ear the nerve of hearing gradually deteriorates. This is probably due to disuse atrophy.

I would like to point out in reporting the present-day results of the fenestration operation for otosclerosis that we are dealing with a condition which no other form of medical treatment has been able to improve or prevent. All previous efforts have resulted in failure, and these patients have been doomed to deafness. The return of normal hearing in 60 to 65 percent of the cases operated should be considered as a marvelous achievement; however, constant efforts are being made through research further to improve these results. The fenestration operation is considered by otologists to be the outstanding contribution to this field in our time.

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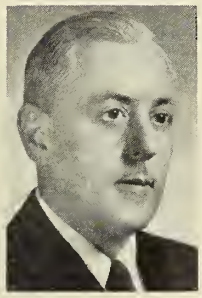
THE SAFETY OF CESAREAN SECTION*

Carl P. Huber, M.D.

Indianapolis



The Author:

Doctor Huber is professor and chairman of the Department of Obstetrics and Gynecology at Indiana University School of Medicine. He is a graduate of the University of Michigan, having received his M.A. degree in 1925 and his M.D. in 1928. He was instructor on the teaching staff of the University of Michigan and the University of Chicago until 1938, when he came to Indiana University. He is a member of the Central Association of Obstetricians and Gynecologists, Chicago Gynecological Society, the Board of Directors of the American Committee of Maternal Welfare, the American Gynecological Society, and vice-chairman of the International and Fourth American Congress on Obstetrics and Gynecology.

AT THE Indiana University Medical Center there have been five deaths of patients delivered by Cesarean section during the past ten years. A review of the records of these patients indicates that in each instance there was a satisfactory indication for the operation. A short summary of each history is given.

1) XC-44474 Age 26 Gravida I-Para O 1941 Hospitalized 10/23/40 to 11/27/40. Mental deficiency. Dwarfism (4′ 4¾″ and 80 pounds). Syphilis. Normal blood pressure. Afebrile. No urinary tract symptoms, but pus in urine. Antiluetic therapy. Urinary antiseptics. Readmitted 12/13/40. Urea clearance 17 percent and 8.9 percent of normal. Progressive renal failure. Thirty-four weeks gestation. Classical Cesarean with tubal ligation 12/27/40 using ½ percent novocain infiltration anesthesia. Living, 4 pound, 10½ ounce infant. Patient died 1/13/41. Autopsy. Acute suppurative nephritis. Multiple lung abscesses. Friedlander's bacillus on culture. Kidney damage antedated delivery and there was almost complete destruction of both kidneys.

2) XC-60960 Age 28 Gravida I-Para O 1942 Normal term twin pregnancy. Failure of progress in labor. Contractions poor. Cervix 80 percent effaced and two fingers dilated after 18 hours. Membranes ruptured. Low cervical Cesarean section under ether anesthesia. Living infants. Impaction of head of second infant between head and shoulders of first. Blood loss 500 cc. Sudden collapse with death at completion of abdominal closure. Autopsy. Pulmonary edema secondary to acute circulatory collapse.

3) XC-62828 Age 27 Gravida II-Para I 1942 Admission as an emergency following six convulsions. Early labor. No progress. Conservative treatment. No convulsions following admission. Coma. Term pregnancy. Artificial rupture of membranes eight hours after admission. Contractions weak. Low segment Cesarean under 1 percent novocain infiltration. Living, 6 pound, 4½ ounce infant. Death thirty hours after delivery. No autopsy. Eclampsia. Right hemiplegia. Cerebral hemorrhage.

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4) XC-74081 Age 21 Gravida I-Para O 1943
Hospitalized six weeks from term for treatment of preeclamptic toxemia. Decrease in albuminuria. Blood pressure stabalized at 150/100. Symptomatic improvement. Rise in blood pressure, severe headache, epigastric pain on eighteenth hospital day. Immediate delivery by Cesarean scheduled. One convulsion during course of preparation. Low segment Cesarean under sodium pentothal anesthesia. Living, 4 pound, 5½ ounce infant. Death six hours following delivery. No autopsy. Eclampsia.

5) XC-78384 Age 31 Gravida V-Para IV 1944
Emergency admission. Thirty-four weeks gestation. Edema and hypertension during last pregnancy in 1942. Well in interval. B.P. 200/130. Congestive heart failure. Urea clearance 16 percent T.N.P.N. 46 to 140 day of delivery. No decompensation. Classical Cesarean with tubal ligation under ½ percent novocain infiltration anesthesia. Living, 4 pound, 10 ounce infant. Death sixty-seven hours after delivery. Autopsy. Bilateral hypostatic pneumonia. Left ventricular cardiac hypertrophy. Left renal aplasia. Right contracted kidney. Uremia. Hypertensive cardiovascular renal disease.

There were no contraindications to abdominal delivery in these patients. Termination of the pregnancy was essential. Three of the five patients would have died if undelivered or if delivery could have been accomplished by any other means.

TABLE I

These are cases 1, 3, and 5. Case 2 must have been a preventable death. Whether the depth of anesthesia or unrecognized myocardial damage played a part could not be determined. The marked abdominal distention of the multiple term pregnancy with rapid release during abdominal delivery may have been a factor. Case 4 also has to be considered preventable. This is true if the pregnancy had been terminated earlier. The toxemia became suddenly fulminating without prior warning and in spite of apparent improvement under therapy.

The frequent causes for death associated with Cesarean delivery are infection, shock, hemorrhage and the pregnancy toxemias. The choice of the time for the operation, the type of anesthesia used, the recognition of impending shock, the replacement of blood loss, the postoperative management, and the type of operation influence the safety of the procedure.

The maternal mortality for Cesarean section should be less than 1 percent. The risk for the patient who is delivered by Cesarean is greater than that for vaginal delivery. In our series there were 888 Cesarean sections in 14,185 deliveries from July 1, 1939, to June 30, 1949. The mortality rate was 0.56 percent. From July 1, 1944, to June 30, 1949, we have performed 485 Cesareans without a maternal death. During this five-year period there were 8,294 deliveries with a gross maternal loss of 1.7/1000 deliveries and a gross infant loss of 36.0/1000 deliveries. This includes all infants weighing 1000 gms. (2.2 pounds) or more.

TABLE II

The decision to perform a Cesarean section is always an important one. The possibility of vaginal delivery should be weighed. Forceps delivery or version may be safer. A few more hours of labor may safely eliminate the necessity of abdominal delivery.

The infant should be alive, undamaged and without gross abnormalities. Every labor should be so conducted that the risk of ultimate Cesarean delivery is at a minimum.

Elective section for disproportion is seldom indicated. Dieckmann[1] states that only a true conjugate diameter less than 8.0 cm. or a biischial diameter less than 7.0 cm. is an indication for section without trial labor. This should consist of labor for twelve to fifteen hours, with uterine contractions of good quality at three to five minute intervals, lasting at least thirty-five seconds. A minimum of rectal examinations are done. A vaginal examination should be done before deciding upon Cesarean section. If progressive dilatation of the cervix and descent of the head is not

TABLE I
CESAREAN SECTION DEATHS

Patient	Indication	Operation	Cause of Death
1. XC-44474	Renal Failure	Classic	Suppurative Nephritis
2. XC-60960	Twins—Failure of Progress	Lap-Trach.	Circulatory Collapse
3. XC-62828	Severe Eclampsia	Lap-Trach.	Cerebral Hemorrhage
4. XC-74081	Fulminating Toxemia	Lap-Trach.	Eclampsia
5. XC-78384	Cardiovascular Renal Disease	Classic	Uremia, Bilateral Hypostatic Pneumonia

TABLE II
CESAREAN SECTIONS
WM. H. COLEMAN HOSPITAL

Date	Total Deliveries	Mortality Maternal	Mortality Infant	Cesarean Sections	Cesarean Mortality
July 1, 1939 to June 30, 1949	14,185	3.0/1000	39.0/1000	888	5—.56%
July 1, 1944 to June 30, 1949	8,294	1.7/1000	36.0/1000	485	0— 0%

occurring Cesarean section is performed. Many sections done for cephalopelvic disproportion are in patients whose uterine contractions are ineffective. Rupture of the membranes artifically when the head has entered the pelvis may result in more effective contractions and definite progress. Douglas and Landesman[2] report that the administration of penicillin and sulfadiazine prophylactically in patients subjected to trial labor decreases the risk. A decision should be made before the patient has been in labor twenty-four hours or before the membranes have been ruptured twenty-four hours. The mortality should not be greater than 0.4 percent after a properly conducted trial labor, according to Dieckmann. There is no excuse for Cesarean section after attempts at vaginal delivery. The survival of the patient under such conditions is fortuitous and not the result of obstetric judgment. Repeated vaginal examinations and frequent rectal examinations may be nearly as hazardous.

The patient who has had a previous Cesarean section has a safer future if all of her pregnancies are terminated by Cesarean section. There is no way that one can predict the character of the uterine scar. Ruptures occur more frequently in the scar following the classical incision than after the low cervical incision. A weak scar is not infrequently encountered at the time of repeat section. This is true even where there was no infection and good technique had been used. Forty-three percent of the Cesarean sections done at Indiana University during the last five years were repeat sections. This is evidence of the importance of making the correct decision when the first section is performed. Care must be used in determining the time for performance of a repeat section. It should be done 7-10 days before term, but where the history is indefinite one should be sure that the fetus is of sufficient size. The number of Cesarean sections is wisely limited. We perform tubal ligation after the second section, if requested, and suggest it at the time of the third section. This does not limit the desired number of children in most instances.

Cesarean section is usually the safest form of delivery for the patient with placenta previa. Many multiparae with a marginal implantation and some patients with a partial placenta previa can be delivered vaginally following rupture of the membranes. All complete previas and most incomplete ones in the primigravida are best managed by Cesarean section. Replacement of blood loss before, during and after delivery is essential.

The conservative management for patients with severe abruptio placentae as reported by Gustafson[3] is our routine. Cesarean section is performed in the interest of the infant where partial separation is encountered and in those patients with severe separation who fail to progress after rupture of the membranes. Adequate blood transfusion is a livesaving measure. As much as 3,500 to 4,000 cc. of blood may be necessary in these patients.

Eclampsia is not an indication for Cesarean section. The severe eclamptic patient, after ten to twelve hours of medical management may justifiably be delivered by section. It should never be the primary approach to therapy.

The patient with cardiovascular renal disease and the preeclamptic patient are often wisely delivered by Cesarean before term at a time when treatment has resulted in an optimum state but the toxemia persists. Local and regional anesthesia contributes to the safety of these patients.

Other indications for Cesarean section, such as malpresentation, postmaturity, breech presentation, and elderly primiparity, are relative and require careful consideration and good obstetric judgment.

It is always to be remembered that Cesarean section does not guarantee a live, undamaged infant. The hazard of prematurity, the anoxia associated with prolonged labor, placenta previa, and abruptio placentae, and the effect of the pregnancy toxemias may produce infant loss. Acken[4] states that the fetal mortality in Cesarean section is higher than that for vaginal delivery. Prematurity is the greatest single cause of fetal mortality in Cesarean section. It occurs most often in conjunction with placenta previa. Local infiltration or spinal anesthesia contributes to the safety of the infant delivered by Cesarean section.

There is no question but that the low cervical Cesarean is the safest type of operation to perform. Five of every six Cesareans in our series were laparotrachelotomies. Most of the classic operations were done upon patients who were also sterilized. The immediate course of patients following the low segment incision is smoother, the morbidity is less, the danger of infection is miminal and the obstetric future is safer. There were no extraperitoneal operations in the series. None of the deaths were due to infection.

We believe that the low cervical Cesarean is a safe operation when done at the correct time, for adequate reason, and in the absence of contraindications. Beware of the patient who has been in labor for more than twenty-four hours, whose membranes have been ruptured for more than twenty-four hours, or has had repeated rectal or vaginal examinations, and particularly who has been subjected to attempts at vaginal delivery.

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THE USE OF INTRAVENOUS PROPYL-METHYL-CARBINYL ALLYL BARBITURIC ACID* FOR HYPNOSIS DURING NITROUS OXIDE ANESTHESIA†

Preliminary Report

V. K. Stoelting, M.D., J. P. Graf, M.D. and G. W. Rasch, M.D.

INDIANAPOLIS

MANY members of the barbituric acid series have been investigated with reference to their use as hypnotics in anesthesia. Fitch, Waters, and Tatum,[1] in their extensive work on barbituric acid derivatives, emphasized the importance of using short-acting members in anesthesiology.

The sodium salt of propyl-methyl-carbinyl allyl barbituric acid (seconal sodium) appears to be a desirable compound for use in anesthesia. Swanson[2] reported the use of this drug in dogs. His findings showed seconal sodium to give slightly longer anesthesia[3] than pentobarbital sodium, and comparable to anesthesia obtained with sodium amytal. The time for complete recovery with seconal sodium, however, was one-half that of sodium amytal and slightly less than that of pentobarbital sodium.

Many reports in the literature in recent years have advocated heavy barbiturate premedication prior to nitrous oxide anesthesia. Although pentothal sodium is an excellent drug with nitrous oxide during short procedures, it has been our experience that the drug has accumulative action when given over long periods. It was felt that seconal sodium given intravenously just prior to nitrous oxide anesthesia would eliminate the use of pentothal sodium or at least reduce the amount of the drug required during surgery.

The seconal sodium used in this study was prepared in 5 cc. ampules containing 250 mg. of the salt dissolved in a 50 percent carbowax vehicle. Each 5 cc. ampule was diluted to 20 cc. with saline or distilled water before injection. In this study seconal sodium was administered without exception by the intravenous route. A three-way stopcock inserted between the needle and fluids for intravenous use made this a simple procedure.

This drug was administered to 350 patients.

Nitrous oxide was the principal anesthetic agent in 131 patients. Nitrous oxide and pentothal sodium was used in 198 patients. Cyclopropane was used in fifteen cases and ether in six instances.

The carbon dioxide absorption, semiclosed circle or to-and-fro filter technique was used for the administration of the inhalation agents.

Patients in good condition were given 250 mg. of seconal sodium at a single injection. If the degree of hypnosis was not obtained in three to five minutes, additional injections of 25 to 75 mg. of the drug were given at three to five minute intervals until the desired degree of hypnosis was obtained.

Twenty-six patients had not regained active reflexes prior to leaving the operating room. Two-hundred and six patients were awake, talking rationally, and obeying commands when removed from the operating room suites. These patients remained awake and cooperative after being returned to bed on the ward. One hundred and eighteen patients regained active reflexes but remained drowsy and sleepy for four to five hours after operation.

DISCUSSION

Seconal sodium has many of the disadvantages of the other barbiturates, principally respiratory depression and initial drop in blood pressure. Although only two very mild laryngospasms were encountered, these should serve to make us cautious. Postoperative drowsiness was also seen, especially where large doses of seconal sodium were used, or where the anesthesia time was less than one hour.

Most of the complications occurred in patients receiving more than 250 mg. of the drug. The total dose should be limited to 250 mg. and pentothal sodium administered for additional hypnosis. Seconal sodium should be reserved for cases in which the estimated anesthesia time is one hour or more. The number of patients not responding or exhibiting active reflexes immediately after completion of the operation will be reduced if the above precautions are observed.

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* Seconal Sodium—supplied through the courtesy of Eli Lilly Research Laboratories, Indianapolis, Indiana.

† From the Department of Anesthesiology, Indiana University School of Medicine, Indianapolis.

The advantages are those of any intravenous barbiturate, namely: quick, pleasant induction, easy control of anesthesia, and a low incidence of postoperative nausea and vomiting. The initial dose of seconal sodium may be given and anesthesia maintained for long periods of time with nitrous oxide alone. Pentothal sodium was frequently necessary to produce a more profound hypnosis after the administration of intravenous seconal sodium. However, the amount of the drug administered was definitely less and the patients did not show a cumulative effect as is frequently seen when pentothal sodium is given alone with nitrous oxide over long periods. The incidence of laryngospasm was very low, as compared to pentothal sodium.

We feel that seconal sodium has a definite place in the armamentarium of drugs used by the anesthesiologist and certainly deserves further clinical investigation.

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EDEMA OF THE VULVA IN PREGNANCY

Report of Three Cases

David A. Bickel, M.D. and Paul G. Seyler, M.D.*

SOUTH BEND

MASSIVE edema of the vulva is not a common complication of pregnancy. It is even an infrequent accompaniment of the generalized fluid retention associated with pregnancy toxemia.[1, 2] Because of the rarity of the condition only reports of isolated cases appear in the literature. The three cases in this report were the only instances of the condition observed in more than ten thousand pregnancies.

CASE I

An 18-year-old primigravida was first seen on June 29, 1948, complaining of swelling and pain of the vulva of 24 hours duration. She was then approximately six months pregnant, her last menses being December 15, 1947, and the expected delivery date being September 22, 1948. There was nothing in the clinical history of importance except minimal ankle edema since the time of conception. The patient was in good economic circumstances, and her diet had been adequate.[3] On admission, findings included temperature 99 degrees, pulse 84 and blood pressure 110/80. Physical examination showed a young woman approximately six months pregnant with no unusual findings except massive edema of the vulva (Figure 1.) The laboratory findings were: red blood count 5,020,000, white blood count 10,000, hemoglobin 14.4 grams percent, with a differential count within normal limits. Serology was negative, and the serum protein was 6.2 grams percent. The urine showed specific gravity of 1.021, 3 plus acetone, 1 plus albumin, and 3 to 5 pus cells per high power field.

Figure 1

The patient was given a salt-free high protein diet, ammonium chloride 8 gms. daily, liberal sedation, and ice bags were applied to the vulva for one week. There was no relief of pain and no decrease of the edema. The labia were aspirated and 400 cc. of clear fluid of specific gravity 1.002 removed with complete relief of symptoms. Culture and smears of this fluid were negative. The labia were aspirated again the next day; the patient was then able to walk about and was disharged the following day.

The edema of the vulva recurred, and aspiration was repeated on two occasions, but relief was only temporary. During the next month her blood pressure remained stationary, and the albuminuria did not increase, but the vulvar edema increased, and there were signs of free fluid in the abdomen.

On July 31, 1948, under cyclopropane anes-

* From the Department of Obstetrics, St. Joseph Hospital, South Bend.

thesia, a low cervical section was performed, and a premature female infant delivered. Upon opening the abdomen, the subcutaneous tissues were found to be edematous, and the peritoneal cavity contained great quantities of free fluid. Also, considerable hydramnios was present, and an incidental finding was a bicornate uterus. The postoperative course was uneventful. The edema of the vulva and lower extremities had completely disappeared in four days, and on the day of discharge the blood pressure was recorded at 110/75. The infant, moderately jaundiced and somewhat cyanotic, expired some fifty hours after delivery of prematurity.

CASE II

This patient, a controlled diabetic whose expected delivery date was April 8, 1944, was well until January of 1944, when albuminuria and considerable edema of the lower extremities and vulva appeared. Throughout pregnancy occasional glycosuria occurred and the blood sugar varied from normal to 214 mgm. percent. At no time during pregnancy was a blood pressure higher than 125/75 recorded.

Adequate insulin therapy, a high protein and essentially salt-free diet, and ample sedation were given. During the next month the albuminuria did not increase, but the vulva became so distended that the skin and mucous membrane appeared as a thin, tightly stretched membrane covering a mass almost as large as the patient's head. The edema was even more pronounced than in the previous case. On February 14, 1944, a low cervical Cesarian section was performed, and a premature baby delivered, which died five days later. The edema and all other signs of toxemia disappeared promptly.

During the patient's second pregnancy, there were no signs of toxemia. A section was performed in August of 1947, and a normal, healthy infant delivered.

The patient had a third pregnancy which was terminated at 35 weeks in December, 1949, by section and hysterectomy. A premature but normal infant which survived was delivered. Hormone therapy was not used in any of these pregnancies.

CASE III

This patient was a 27-year-old primigravida whose past medical history was irrelevant. She was first seen when about three months pregnant. (The expected date of delivery was October 5, 1949.) At that time her weight was 117 pounds, blood pressure 110/72, serology negative and hemoglobin and cell counts within normal limits.

The pregnancy progressed normally until the sixth month, when painful and massive swelling of the vulva appeared. Edema could not be demonstrated in other tissues, and the rate of weight gain was not excessive. On two occasions fluid was aspirated from the vulva. There was some improvement, but considerable edema persisted. When examined in August, 1949, which was about two months after the onset of the vulvar edema, her total weight gain was only 16 pounds. There was no increase in blood pressure and only a trace of albumin in the urine. Her diet had been adequate, and there was no anemia. On August 11 she had a sudden attack of severe, constant abdominal pain—the picture of premature separation of the placenta. A section was performed; the placenta was partially separated, and the uterus contained a large amount of blood. A premature infant was delivered which survived. The patient made an uneventful recovery, and the edema of the vulva quickly subsided.

DISCUSSION

It is well known that vulvar reactions may occur secondarily to many systemic diseases, such as blood dyscrasias, uremia, diabetes mellitus, vitamin deficiencies, protein deficiency, and allergic dermatitis.[4] Vulvar edema, however, is almost invariably associated with the toxemia of pregnancy, cardiac or renal disease, or with hepatic disease involving obstruction of the portal system. The large amount of areolar subcutaneous tissue, the folds of easily distended skin, and the abundance of blood and lymph vessels permit great fluid retention in the vulva.

The cases presented were part of the general picture of toxemia of pregnancy. All of the cases became progressively worse as the pregnancy progressed. All were rather resistant to the usual medical management. Termination of the pregnancy resulted in a rapid return to normal in all the patients, suggesting a hormonal or mechanical etiology of the condition.

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ASSAULT WITH A DEADLY WEAPON

TRAFFIC fatalities in Indiana in 1949 rose to an eight-year record of 1,118. This is but a slight increase over the 1948 toll of 1,071 lives, yet it represents the worst record of any year since 1941.

Action was taken by the executive committee and the executive board of the Indiana Traffic Safety Council at its meeting recently to re-intensify the program to promote traffic safety. A study and analysis of the state's traffic record will be undertaken in an effort to develop facts upon which a safety campaign may be based.

The first Indiana Traffic Safety Council was organized in 1937 by Governor Townsend and Mr. Paul G. Hoffman. Its executive committee serves in an advisory capacity to the Indiana Traffic Safety Commission, an official body which was created by law in 1947. Both the council and commission have been blessed with hard working and public spirited citizens as members, and have had the support of many public organizations and trade and professional associations.

Despite hard work and cooperation, and notwithstanding the fact that everyone is agreed on the need for safe driving, the absolute number of highway deaths is now on the increase. Due to the increase in number of cars and due to the fact that the average number of miles driven by each car owner has increased by about 2,000 miles per year, the fatality rate per highway mile traveled has decreased.

However, a decrease in the rate per mile is cold comfort, when it is remembered that over a thousand lives are lost each year in Indiana by a means which is almost wholly preventable. A slight decrease in mortality rate is nothing to rejoice about when the entire death list is unnecessary and 99 percent due to negligence.

Overcrowding of the highways, obsolescence of automobiles, overdue road repairs, and increased use of motor vehicles are all offered as factors in the traffic toll. These factors, no doubt, have some bearing on the question, but when one considers that safety awards are given each year to drivers who have driven in the most crowded conditions, in all kinds of weather, tens of thousands of miles per year, without denting a fender, one must conclude that there is only one place to look for the cause of highway deaths.

The driver is the one who is responsible for our highway loss and until his actions can be controlled no marked amount of improvement may be expected. The basic trouble is that we have 100 horsepower automobiles with too many one horsepower brains driving.

Since general appeals to the public and other

measures are not solving the problem, there remain but two effective control methods. One of these is to limit by law the power that may be built into an automotive vehicle; the other is to eliminate the vast number of negligent and irresponsible drivers.

These are both drastic methods. The first is undesirable because it would deprive careful and conscientious motorists of the advantages which the modern car has afforded and which if used wisely are not dangerous. The second method is extremely difficult of execution. However, if it could be made feasible, the first method would not be necessary.

The Indiana Traffic Safety Council has accepted the challenge of solving the problem and may be depended upon to exert every effort. The Indiana State Medical Association is represented on the council, and individual physicians will do well by assisting in its work whenever possible. The traffic death epidemic is more hazardous than many of the specific diseases to which public interest and finances have been drawn. The toll of misery and financial loss occasioned by nonfatal highway accidents is in itself worthy of heroic control measures.

In the meantime the best driving rule to remember is: "Drive as though all other drivers on the road are insane." In many cases one will not be wrong in such an assumption.

COMPULSION VERSUS FREEDOM

CECIL PALMER, English publisher and journalist, in lecturing on British Socialism, emphasizes again and again that compulsion is an essential feature of a socialistic program. Soon after the inception of the British Health Service, regulations were issued to the effect that all physicians were required to make complete records of the diagnosis and treatment of each case, and that these records were to be made available to the lay councils upon demand. This, in spite of the many assurances made prior to the scheme that the traditional doctor-patient relationship would not be disturbed.

There have been other evidences that the British, in adopting socialized medicine, have tried to retain some of the advantages of free medical practice, but have had to abandon them when they found that they were incompatable with socialism in practice.

Recently Mr. Aneurin Bevan, Minister of Health, in a press interview stated that "the doctor must be free to prescribe what he considers to be necessary for the care and welfare of his patient." Later in the same interview he said that "he had asked a small specialist committee to draw up a list of drugs which the general practitioner can prescribe which are adequate for the purpose and outside which the general practitioner need not go except in special cases."

On the same day Mr. Bevan stated that he was emphatically opposed to any direct payment which might be levied on the patient at the time of service. He said that in the first year of the BHS 14,000 chemists had filled 187,000,000 prescriptions. This was what he called "overprescribing," and he thought it should be controlled by appeals to the patients, rather than by setting a nominal fee for each prescription. Since that time a nominal fee of 14 cents has been established, in an effort to limit the tremendous cost of "free medical care."

After a little more than a year of socialized medicine it is becoming apparent that the British must not understand how socialism really functions. They have evidently started out to have all the advantages of an unregimented system of medical care, and all the supposed advantages of the socialistic system. They are being forced to abandon, one by one, the confidential doctor-patient relationship, the freedom of a doctor to prescribe, and, due to the greed of the people, the ability to provide free medicinals.

They are finding out that socialism is like pregnancy, one cannot have a little of either. A little socialism will slowly but surely crowd out all freedom. Socialism in one profession will slowly but surely spread to other portions of the economy.

John McPherrin, editor of *The American Druggist*, in an interview last year with Mr. Bevan, asked the Minister if it would not have been better to have introduced socialistic practices into England gradually and thereby have avoided many of the mistakes. Mr. Bevan's answer was to the effect that the changeover must necessarily be sudden and complete, and that the Minister must be the master.

Dictator is a better word.

RURAL HEALTH COUNCILS

MUCH has been said and many invectives have been let fly in a negative way against state, or political, medicine, but constructive and positive action by the medical profession, its ancillaries, and collaborators, seems still in an early stage of experimentation. It is refreshing and stimulating to find one of these attempts at positive, remedial action being made in North Carolina. There is an old saying in that region of being willing to "take a 'tater and wait," but this time they have taken a 'tater, and planted it, —and have done some cultivation of the soil. The results are apparently most encouraging, as reported to their state medical society and printed in its journal for January, 1950:

The story of the development of the Rural Health Councils so far reads like fiction, and the interest being shown among the rural people is almost unbelievable. They have expressed themselves voluntarily as favoring the democratic way of solving their own medical problems and working out their own salvation, with some direction on the part of the medical organizations of the state.

I want to say that the cooperation of the State Health Department, the School of Public Health at the University, the medical schools, the home economics and welfare groups, civic clubs, and, most important of all perhaps, the different farm groups, has been just about 100 percent. It is refreshing and satisfying to see the willingness and enthusiasm shown by all these groups in working to the end that our state shall have "adequite health and medical care for the people of rural North Carolina."

We feel that in this field, as in many other programs in former years, North Carolina is right out in front. I doubt that any other state in the Union now has actually organized a rural health council in the strictest sense of the word. However, the interest at national and sectional as well as state meetings has been intense, and everybody seems to be more health conscious than at any other period in our history.

That this represents a truly "grass-roots" approach to an important aspect of the total problem of providing medical care for the U.S.A cannot be gainsaid. Here is one field, at least, where the private practitioner can learn to coöperate with the public health physician. Furthermore, it appeals to us as a field peculiarly suited to the talents, training, and experience of the general practitioner, although no physician, of course, should hold back if asked to aid in such a project. Indiana has already embarked on this venture in a number of counties and the idea probably will spread.

Editorial Notes

SUGGESTIONS REQUESTED FOR THE 1950 YEAR BOOK

Plans are now being made for the publication of the Indiana Medical Year Book as the July 1950 issue of THE JOURNAL. As formerly the Year Book will contain the association membership roster, a directory of state medical organizations and state boards, lists of state hospitals and nursing homes, and other reference information. In addition, authoritative articles on medicolegal subjects will be included. Members of the association are invited to submit requests for such articles, or for the inclusion of other types of reference material. Address THE JOURNAL of the Indiana State Medical Association, 1017 Hume Mansur Building, Indianapolis 4, Indiana.

Many types of letters are addressed to the president of the American Medical Association, but Dr. Ernest E. Irons received one last week that is a No. 1 morale builder.

The letter did not come from a doctor. It was written by Mr. Joseph Christensen, of the Progressive Cafeterias in Chicago, and reads as follows:

> "I cannot put M.D. after my name but I can, at least for a while, still put U.S.A. As a consequence, please accept the enclosed check for $25 as a slight token of regard for my doctor and all his colleagues. These are my 'dues' as a citizen, and I hope they will help in your fight against socialized medicine.
>
> "A people without guts are soon a nation without guts, and if it should become necessary to remove any part of mine, I want to pick my man and pay his charge without a precinct captain getting his nose in my anatomy."
>
> *Secretary's Letter, A.M.A., January 16, 1950.*

Volume 1, Number 1 of the *United States Armed Forces Medical Journal* appeared in January. This is a new journal, published for the information of the Medical Departments of the Armed Forces. It replaces the Bulletin of the U. S. Army Medical Department, published since 1922, and the U. S. Naval Medical Bulletin, published since 1907. It is jointly published by the Medical Departments of the Army, Navy and Air Force. The editor is Joseph L. Schwartz, Captain, MC, USN. Associate editors are Wayne G. Brandstadt, Lt. Col., MC, USA, and Alfred A. Gentilcore, Capt., MC, USAF.

Vanderburgh County Medical Society received out-of-state congratulations and favorable comment on its public relations program, in the *Kentucky Medical Journal* issue of January, 1950. A brochure entitled "We're Doing Something about Public Relations in Vanderburgh County" is what caught the eyes of our confreres in Kentucky. This attractive and very readable and compact pamphlet explains to the public what the county society is doing about public relations. Under the heading "Building Public Respect" are given the details of their activities in civic cooperation, graduate education, around-the-clock service, polio emergency, Blue Cross-Blue Shield, public health, health management, socialized medicine and diabetes survey. The brochure is very well gotten up and we feel sure that any member of the state association who is interested may obtain a copy by addressing the executive secretary, Mr. Arthur Tiernan, City-County Health Bldg., Evansville, Indiana.

The Vanderburgh County Society is also due congratulations for a special 14-page Health Section of the Sunday *Courier and Press*, which was published on January 29, 1950, to help the society celebrate its 105th birthday.

President's Page

SYMPTOMS OF SPRING

ALTHOUGH we have had spring weather most of the winter, we can begin to notice symptoms of the official spring season—flowers pushing up toward the sunshine, farmers preparing to seed for their crops, and stump speeches by political candidates hoping to clear the first hurdle of election year.

As our rural friends are preparing to sow the seeds that will grow into the crops which provide their livelihood, we as medical men must sow the seeds of kindly, competent service which will grow into the public support that is the basis of our livelihood. The other day I listened to a group of men discussing the trouble within the coal industry. One of them said, "The people want the government to operate the mines. The people want socialized medicine, too, because they need it." The solution to the problems of medicine and mining all in one breath! Now I personally considered that a subversive statement because it struck at my profession, yet it was also a symptom—a danger signal. It meant that some people are not only dissatisfied with the medical service they are getting, but they are talking about it in terms which undermine us, our work, and our status as a free profession. Perhaps some doctor, somewhere along the line, failed to treat a patient with courtesy and consideration for the person's ability to pay. One such instance could strengthen the crusade for socialized medicine and gain any number of converts for our opposition.

The American Medical Association and the Indiana State Medical Association are applying organized effort to protect the American way in the practice of medicine. Organized effort is expedient and necessary, but remember that it cannot take the place of satisfactory service rendered punctually and cheerfully.

E. S. Black

Medical Panorama by the Associate Editor

Those A.M.A. Dues

Questions (and, we are sorry to say, some grumblings) anent the recently voted A.M.A. dues have cropped up in the Northwest as well as in the Mississippi Valley. *Northwest Medicine*, in its January 1950 number, carries an editorial which we believe hits the nail right on the head and drives it well into the wood.

The new dues are compulsory. Members have thirteen months to meet this just obligation or forfeit membership in the A. M. A. The *Journal* subscription of $12 per year is in addition to the new dues. Although membership in the county society or state association is not involved if the $25 is not paid within thirteen months, it has been well pointed out that members should "stand up and be counted," that the "piggy-back riders" should be shaken off and not be allowed to comingle with those who carry their rightful burdens in the fight to preserve a free medical profession.

A suggestion for those who feel the added $25 dues bends the back too low is to discontinue donations to less important activities, to quit an unnecessary social club or forego other pleasures so that we can present a united front against an insidious enemy. Naturally, the retired physician, the non-dues-paying sick, or the low-paid internes and residents will not be expected to pay the new levy upon proper showing, but most of these individuals will want to participate in this activity to whatever extent they can.

It is expected that the membership will readily respond to this call for new dues, thus assuring the A. M. A. sufficient funds with which to step up its promotion of prepaid medical programs and to continue its defense of free enterprise in America.

The time is past for placation or appeasement and also for unsoldierly bickering within the ranks. Our delegates in session assembled voted for the precedent-shattering dues and it is up to each member of the association to assume his share of our collective burden cheerfully,—nay, thankfully: thankful that he can do this much without being "sent to Siberia" (yet).

"The New Pilgrims"

The current problems of the Displaced Person who seeks rehabilitation in the New World have received a great deal of attention these past few months. Our seaboard sister states have, naturally, been more affected than we have in Indiana. However, there is one angle to the "proposition" which has been worked out as logically as geometry by our New York brethren and commented upon editorially in the *New York State Journal of Medicine* for January 1, 1950. This number inaugurates the Golden Anniversary Year of that journal and we would like to compliment them by quoting as follows, in part:

From Great Britain and the continent of Europe again come pilgrims. They flee the recurrent tyranny of dictators and state-controlled economies used as bludgeons to coerce citizen-taxpayers through "regulation" by "welfare" states!

Precisely as in 1620 individuals of courage, having no stomach for the heavy-handed, tyrannical, and cynical "regulation" of minorities, of which medicine is one, seek sanctuary here with us.

The medical pilgrims, looking about them, and still licking their professional wounds of the mind, body, and spirit, find us here engaged in a controversy. This controversy, curiously enough, centers about the question whether we should by law in the United States institute the very system of national compulsory health insurance, from the intolerable controls, red tape, and tyranny of which they have just fled!

* * *

Should those in and out of the government who advocate national compulsory health insurance prevail in writing it into the statutes, how long would it be before the same bureaucratic tyranny, red tape, controls, and regulations would make the practice of medicine here a stench in the nostrils of free men?

Then what of the pilgrims? Could they stand better here that thing which drove them from their former homes? And if neither they nor many of us could long endure it, where, to what place, could we make our pilgrimage? New Zealand?

Your guess may be better than theirs (or ours!) but we doubt it. It doesn't require a Daniel to read the handwriting on Harry's wall, unless you belong to the none-so-blind-as-those-who-will-not-see classification.

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

WE'LL NEED A FREE HEALTH PLAN WITH A BUDGET SUCH AS TRUMAN SUGGESTED

HENRY MCLEMORE

Up until the time of President Truman's budget talk I was against his national health program.

I had not read more than half of the President's budget speech before I realized that his national health program was completely necessary.

With that sort of budget someone has got to take care of a fellow when he becomes ill—he certainly won't be able to take care of himself.

When we get a cold, or a touch of croup, or a giddy spell in our head, we won't be able to call up doctors the way we used to because we won't have any money with which to pay them.

I hate to see the passing of doctors. In many ways they have been closer to the American family than any other professional men. The family doctor was the one man you could talk to. He was the one man who would get up at all sorts of hours and come to see you. He was the one man who knew you were being alarmed over nothing, but was still nice enough to come and allay your fears.

I wonder if Mr. Truman has ever completely figured out what he is asking this country to give up.

In case he hasn't figured it all out, I'll save him the trouble, because I have.

He and his advisers are asking Americans to give up America. If a halt is not called this country will not be the United States of America. Our heritage is being poured right down the drain. And it is much too fine a heritage to come to such an end. Our heritage is based absolutely on liberty, and that's what is being taken from us every time the clock ticks.

Speaking as an American, I would rather have it all taken in one big bite instead of having it nibbled away. I consider it an insult to my intelligence for my government to think that I don't know what's going on.

If all we were going to lose was money, I don't think many of us would complain. This country has proved its willingness to give away money to the world. This country has an unmatched record of generosity and decency. No one ever called for help and went unanswered.

But there has come a time when we are being asked, under the guise of politics, to quit being Americans. Day by day, slowly and surely, we are being asked to give away our pattern of life for the pattern of life of the Old World. Ours was the pattern of life of the New World.

This country is known as the New World. It seems to me a shame that this country should be asked to walk in the footsteps of countries which have proved themselves failures.

This country was founded on strength and in my book there comes a time when the strong should be protected as much as the weak lest there come a time when there are no more strong to take care of the weak. Excuse my philosophy, readers, but I just had to get it off my chest.

The Indianapolis News.

* * *

AN ANTIDOTE TO SOCIALISM

It is encouraging to see Indiana professional groups combating the threat of Socialism with positive action rather than with reaction. Recently the State Medical Association set up a grievance committee to hear public complaints against member doctors. And now the State Bar Association, currently holding its annual convention here, is preparing a "lawyer's reference plan" to head off socialization of the legal profession.

The reference plan will be explained by Harold J. Gallagher, president of the American Bar Association, at a convention session today. Briefly, it involves allotment of a part of each attorney's work week to serve persons of limited means at a reduced rate. The Indiana association intends to promote the program throughout the state.

Socialized law may seem a fairly remote threat in the United States. But totalitarian philosophies envision it as a part of the ultimate goal. It is never too early to counteract Socialism in any of its aspects. Moves that bring first-rate legal services within the reach of more and more people will effectively cut the ground out from under the busy propagandists who preach socialization of lawyers. Such moves also will help to reduce the discontent on which other phases of the Socialist program thrive.

The Indianapolis Star.

THE CARE OF HAND INJURIES*

Requirements of Early Definitive Treatment

I. The first-aid treatment of hand injuries is directed fundamentally at protection. It should provide protection from infection, from added injury, and from future disability and deformity. This protection is afforded by non-interference with the wound, cleanliness of surrounding areas, the application of sterile protective dressings and immobilization in the position of function.

II. The general requirements for proper early definitive care are:

A. Thorough evaluation of the injury.

1. Determination of the time, place, causative agent and mechanism of the injury.
2. Determination of the nature and extent of the first treatment given.
3. Determination of infection status: Whether the wound is relatively clean, grossly contaminated or with infection established.
4. General nature of the wound, i. e., contusion, abrasion, burn, incised wound, lacerated wound, crushing wound, puncture wound, tooth wound, imbedded foreign body, fracture, compound fracture, amputation or combined injuries.
5. Evaluation of structural damage.
   a. Degree and extent of surface injury.
   b. Source of major bleeding.
   c. Evidence of tendon or muscle damage by testing function *against resistance.*
   d. Evidence of nerve injury elicited by testing for motor and *sensory* functions.
   e. Bone and joint injury determined by x-ray.
   f. Discovery and exact localization by x-ray of suspected opaque foreign bodies.

B. Adequate facilities and equipment.

1. Each hospital or clinic should have at least one surgeon who is thoroughly familiar with the anatomy and physiology of the hand and who is prepared to undertake the early treatment of its major injuries.
2. Such treatment should be rendered under strictly aseptic conditions, preferably in an operating room, with careful adherence to aseptic technic in the matter of scrubbing, draping, masking and the use of gloves.
3. An adequate supply of appropriate instruments.
4. Sufficient assistance to assure good exposure.
5. Good lighting.
6. Provision of a bloodless field by means of pneumatic tourniquet or blood pressure cuff.
7. Complete anesthesia for the patient, preferably by general anesthesia.

C. Application of appropriate treatment.

1. Thorough cleansing of a wide area around the wound with the wound protected. (Entire hand and forearm.) Shaving, soap and water scrub.
2. Thorough cleansing of the immediate wound area, preferably with soap and water or a bland detergent. Antiseptics should not be used in or on the wound.
3. Careful inspection of the wound and assurance of adequate exposure, by additional incision if necessary, *closely paralleling natural creases.*
4. Thorough toilet of the wound, removing, under inspection, all foreign matter. Excision, by sharp and careful dissection, of all completely devitalized or grossly soiled tissue in the wound surfaces. It is essential that the greatest care be exercised to spare all tissues that may be viable, particularly skin, tendon, nerve and bone fragments.
5. Assurance of hemostasis by ligation of major injured vessels.
6. Repair of injured nerves by end-to-end union with fine interrupted perineural sutures. The uniting of divided digital nerves is important to future function.
7. Repair of other soft tissue injuries, where appropriate, i. e., in clean wounds of short duration, in well-cleansed contaminated wounds of not over eight hours duration, never in wounds with established infection.
8. Reduction of fractures and dislocations, and retention in corrected position by traction or splinting in the position of function (position of grasp with wrist in dorsiflexion).
9. Application of protective dressing, fingers separated by gauze and hand immobilized to such extent as may be necessary to permit healing, in the position of function (never in the flat position).
10. Administration of antibiotics and protective antitoxin as indicated.

D. After-treatment.

1. Elevation and rest of the hand.
2. Noninterference with initial dressing for a sufficient time to permit healing, unless evidences of suppuration develop.
3. Restoration of skin coverage of denuded areas at earliest possible time. Partial thickness skin grafting is a simple and valuable means of promoting early healing.
4. Early restoration of function for nonaffected parts of the hand by directed *active* motion to the fullest extent that will not jeopardize healing of repaired structures.
5. Restoration of function in affected parts of the hand by directed *active* motion as early as is consistent with full healing and preservation of the repair of damaged structures.

Subsequent articles will deal with the particular treatment of special types of injuries.

Committee on Industrial Health
Indiana State Medical Association

* Second of a series, prepared by the American Society for Surgery of the Hand, and released by the American College of Surgeons.

CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS

THE annual Conference of County Medical Society Officers was held on Sunday, January 29, 1950, with a registered attendance of 165. This gathering was originated by and has prospered under the chairmanship of Dr. A. M. Mitchell of Terre Haute. Its programs are usually described as being better every year, and the 1950 meeting was no exception to this rule.

The conference was organized for the purpose of exchanging information and ideas, and for the discussion of problems by members and officers of the county societies. The value of such a forum may be indicated by the amount of free discussion which it develops. The conference this year was characterized by inspiring talks and worth-while discussion.

INDIANA'S PROGRAM FOR THE MENTALLY DEFICIENT

Dr. Walter Portteus, chairman, Indiana Council for Mental Health, outlined the functions of the Council, and described the difficulties imposed by inadequate buildings and meager finance. There are now 13,388 patients cared for in the state in buildings which were erected to care for 10,000. The $24,000,000 building program now under way will provide the first major addition since 1900. The Larue D. Carter and Norman Beatty Memorial Hospitals are the two main additions.

The Carter Hospital will not only increase the general patient capacity, but will also enhance the efficiency of treatment by acting as a screening hospital. It will retain patients who give promise of improvement as a result of definitive treatment, and will transfer other patients to existing hospitals for custodial care. It will be the state's only training center for psychiatric nursing, and will also provide clinical facilities for undergraduate and graduate training of physicians by Indiana University School of Medicine.

Discussion by Dr. Walter Kelly developed the fact that county homes and similar institutions may be organized to care for senile cases, which are now increasing in numbers, and do not require as technical a type of care as do the psychoses of nonorganic origin.

Dr. Walter Breutsch discussed the marked decrease in hospitalized cases of general paresis, due to effective treatment of the disease by the use of malaria.

THE IMPORTANCE OF HEALTH EDUCATION

Dr. Byron N. Lingeman, chairman, Committee on School Health and Physical Education, described the two AMA conferences and the Indiana state conferences on school health. He stated that two of the important aims of the health program were immunization of school children and the correction of remediable defects. He considers that a good health education program is the only cure for the tendency of the uninformed public to embrace medical cultism.

A coordinated program with uniform curricula throughout the state was recommended to improve health education. The need for better health teachers, more school health nurses, and more teaching time was pointed out. Increased financial outlay is not necessary, for if the public can be educated so that they will not buy patent medicines, the money thus saved would pay for the health education program.

INDOCTRINATION OF THE COUNTY MEDICAL SOCIETY SECRETARY

Ray E. Smith, executive secretary, Indiana State Medical Association, clarified some questions in regard to dues and classifications of membership as follows:

1. Honorary members are now elected by the House of Delegates. Laymen who have rendered highly meritorious service to medicine, or physicians of special distinction may be so honored.

2. Physicians who have attained 75 years of age and who have been members of the association for a total of 20 years may become Senior Members upon recommendation by their county society. This classification was formerly called "Honorary." The 20 years of membership need not be consecutive, and members are eligible to become senior members in the calendar year following the year in which their 75th birthday occurs.

3. Membership in the 50 Year Club is separate from membership classification. Members are eligible for election 50 years after graduation from medical school and must have been a member of the state association at some time. They are made members by the recommendation of the county societies.

Mr. Smith stated that he had received inquiries concerning the possibility of excusing members who are incapacitated from paying state dues. The by-laws do not provide for this exemption at present. Consideration of a change in by-laws might be in order.

AMA dues will be collected in the same manner as county and state dues.

American citizenship is not a requirement for membership in the state association. Each county society must decide this point for each applicant.

Mr. Smith concluded his talk with a resumé of the activities and services provided for by the state association, in answer to the hypothetical question, "What do I get for my $35.00?".

Mr. Smith said that the secretary of the county medical society should have the answer when a member asked what the state medical association did for him. After pointing out that state membership costs the doctor only 9½ cents a day, Mr. Smith listed a few of the things he receives as follows:

A monthly scientific magazine.

Legal counsel if sued for malpractice.

Answer to legal questions involving his practice.

Privilege of attending a three-day state convention.

Services of seven full-time employees at state headquarters.

Protection against adverse legislation in the Indiana legislature and Congress of the United States.

Thirty-four committees working in his interest, including a committee directing the fight against socialized medicine.

Representation in his behalf with various civic and voluntary health groups.

PUBLIC RELATIONS OF THE COUNTY MEDICAL SOCIETY

Dr. Earl W. Mericle, chairman, Committee on Public Relations, described three principal activities of a county society public relations program, as provision of an emergency call service, maintenance of a speaker's bureau, and improvement of press relations. Lists of doctors who are prepared to accept emergency calls, and calls at night and on holidays should be regularly revised, and should be posted with police and fire departments and at hospitals and telephone answering services. Publicity for this feature should be obtained by advertisements. Organizations, such as the welcome wagon, should be provided with leaflets advising newcomers to make the acquaintance of a family doctor, prior to the time that he is actually needed.

Speakers' bureaus wherever organized have functioned well and have had an increasing number of requests. Conferences between physicians and representatives of the press and radio were recommended, with a view to promoting an understanding of each other's problems.

The afternoon session was opened by greetings from President Claude S. Black, who reviewed the program of the association during the past year and prophesied further accomplishments during 1950.

THE DOCTOR AS A COMMUNITY LEADER

Dr. James L. Doenges, chairman, Committee to Oppose Socialization of Medicine, Madison County Medical Society, described the program of his county society and urged the increasing participation of all doctors in the solution of community problems. He stressed that doctors were prepared by education and conditioned by the nature of their work to assist and advise in all public ventures. Since the busy physician can scarcely "find" the time for such outside activity, it will usually be necessary for him to "take" the time. Dr. Doenges also stressed the necessity for all doctors to be familiar with the details of proposed legislation.

Dr. Walter F. Kelly, senator from Marion County, urged that physicians should be active in political matters, that they should be registered and vote in both primary and general elections, and that increasing numbers of them should consider running for legislative posts.

Mr. Russell I. Richardson, Lebanon, attorney and member of the Indiana House of Representatives, described the rise of British Socialism and told of the effect it was having on the British people. His observations were based on his recent trip to England, and his deductions as to the imminence of such changes in this country and as to the effect on our economy were sobering. He feels that the movement toward socialization of medicine is but part and parcel of the worldwide movement to general socialism, that everyone outside medicine should be concerned about government medicine, and that the medical profession should be concerned about trends to socialism in other professions and in industry.

THE FARM BUREAU LOOKS AT THE RURAL HEALTH PROBLEM

Mr. Anson Thomas, Director, Tax and Legislative Division, Indiana Farm Bureau, traced the development of the Bureau's interest in health problems and described the constructive steps that have been taken to improve rural health. He reaffirmed the stand of the Indiana Farm Bureau against government controlled medicine, and pointed out that his organization was on the side of medicine in the fight for preservation of free enterprise.

WHAT'S GOING ON AT THE A.M.A.

Mr. Thomas A. Hendricks, secretary, Council on Medical Service, American Medical Association, and executive secretary emeritus of our state association, gave an interesting talk, but disclaimed any knowledge of "What's Going on at the A.M.A." In lieu of more definite information he recited his parody on James Whitcomb Riley entitled "And the F.B.I. will Getcha, If You Don't Watch Out." He then outlined the program of the A.M.A. for the future and complimented the state association on its part in the A.M.A. Educational Campaign.

WHAT THE INDIANA STATE MEDICAL ASSOCIATION IS DOING TO FIGHT SOCIALIZED MEDICINE

Dr. Cleon A. Nafe, chairman of the Indiana Campaign Coordinating committee, and James A.

Waggener, field secretary, reviewed the work carried on by the committee during the past year. The report included the fact that Indiana leads the nation in procuring resolutions from groups throughout the state. At the time the report was given, more than 400 Indiana organizations had adopted resolutions opposing compulsory health insurance legislation. It was also noted that more than one and one-quarter millions of pieces of literature had been distributed during the year.

Explaining the plans for the year 1950, it was stated that the committee plans to continue its efforts started in the preceding year. It is the hope that a majority of all organizations will have been contacted and that they too will join in the battle to prevent the trend of socialism in this nation.

Dr. Ralph J. Gampell, self-exiled British physician, debated the issue with a representative of the committee for the nation's health, at Kirschbaum center in Indianapolis on February 5, while Cecil Palmer, noted British author, publisher and journalist of London, England, spoke to large groups in Fort Wayne, South Bend, Evansville, Indianapolis and Gary during the first part of February.

Plans for the advertising campaign and other educational activities for the year were outlined in detail. Special mention was made of the cooperation being given by the Woman's Auxiliary in behalf of the campaign. Reports at the time of the meeting showed that the auxiliary had been successful in getting more than 250 women's organizations to take a stand opposing compulsory health insurance taxes.

HOSPITAL LICENSING COUNCIL*

E. H. Clauser, M.D.†

MUNCIE

INDIANA was one of the first states to have laws relating to licensing of hospitals. The Hospital Licensing Act was enacted in 1945 under the guidance of the Indiana Hospital Association and the Indiana State Medical Association. The law established the Hospital Licensing Council to work with the Indiana State Board of Health, and charged it with the following obligations:

1. To establish rules and regulations for hospitals.
2. To review reports of hospital surveys made by the staff of the State Board of Health.
3. To pass on all applications for license, recommending approval or rejection.
4. To recommend revocation of licenses.

The membership of the Council consists of four hospital administrators, one physician, one nurse, and two ex-officio members, one a representative of the State Department of Public Welfare, and one a representative of the State Board of Health.

After the "General Regulations for Hospitals" had been formulated by the Council and the State Board of Health, the first function of the Council was the study of medical institutions of the state to determine which ones could be licensed as hospitals. A secondary and important function was to assist deficient institutions in meeting the minimum standards of the "Regulations." Conferences are held with hospital representatives in regard to deficiencies, and in regard to the opening of new hospitals.

There have been fifty-one conferences in regard to forty-seven institutions. As a result of these conferences, the Council recommended the following:

Twenty-three applications for licenses to operate hospitals were approved following compliance with the recommendations for improvements.

Eighteen applications were denied or withdrawn by mutual consent.

Licenses were denied to maternity homes operated by practical nurses without trained personnel, hospital facilities, or equipment; to physicians providing labor and delivery in their offices without facilities or personnel for post-partum care; and to physicians maintaining a few beds in connection with their offices for postoperative surgical care but which did not come within the definition of a hospital.

The standards set up by the Council represent a desirable minimum—one that all hospitals will want to attain eventually but one that very few of you have reached up until now. The road to progress is slow, and attainment is difficult. The fine spirit exhibited by you to date in trying to meet recommendations as soon as possible is keenly recognized by all members of the Council.

We realize that the licensing program has come at a time when physical plants and staffs were depleted by exigencies of the war, and that improvements are being made when prices are high and budgets are shrinking. The unprecedented demand for hospital services makes it mandatory to increase the capacity of our hospitals at the same time.

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* Abstracted from an address delivered at a meeting of the Indiana Hospital Association, at Indianapolis, on November 14, 1949.

† Physician member and chairman of the Indiana Hospital Licensing Council.

Since you were faced with problems beyond your control, no survey at this time could show the level of standards maintained by you in more normal times.

The results of the first two surveys of hospitals under the hospital regulations clearly indicate that there are many problems common to hospitals throughout the state. The purpose of this meeting is the joint consideration of these problems by everyone interested in their solution.

The problems that can be solved best on a joint basis are those relating to personnel. Certain other areas, such as environmental sanitation and fire regulations, constitute real problems in nearly every hospital in this state; they are considered in this meeting in order for us to have a clarification of the regulations.

The "General Regulations for Hospitals" provide for a medical staff, which is organized with formal rules and regulations, to hold meetings and to review its clinical work. This provision in no way prevents the right of the free practice of medicine within the scope of the physician's ability. It does not deter initiative nor the exercise of independent thinking on the part of any physician. An organized medical staff is essential in order to establish and enforce standards for medical practice and cooperate with the Governing Board, administrator and other departments of the hospital.

With the increased complication of hospital and medical practice, an organized medical staff is necessary in order for the administration of the hospitals to secure the thinking of the medical staff on all matters of policy relating to patient care. It is also important to physicians that their medical staffs have the privilege and the opportunity to have a voice in establishing standards of care provided patients and in participating in policy formation.

In our first survey of hospitals in Indiana, it was found that 22 percent of hospitals under 100 beds and 52 percent of hospitals over 100 beds had organized medical staffs. In the second survey it was found that 57 percent under 100 beds and 85 percent over 100 beds had organized staffs. Eleven hospitals are in the process of working out their staff organization. The members of the Council feel that the licensing act has been most responsible in effecting this improvement.

We do recognize that if physicians and hospitals fail to accept the privileges for service they now have under recognized administrative procedures freely arrived at, and fail to give this service in a manner acceptable to public opinion, the time will soon come when those privileges will be lost. As a physician having just returned from a visit with doctors and hospitals in England, I feel that the results would be worse than most of us can imagine.

We are not unmindful of many of your complaints against physicians for their failure to serve as a part of a functioning hospital team. Neglect of careful diagnosis and failure to make proper records are the shortcomings of a few physicians. This small minority, however, reflects upon the entire staff. It is a matter for staff discipline, or if this is neglected, may be referred by the administrator to the governing board of the hospital.

We feel that this is a matter in which the state medical association can be of great assistance to physicians and hospitals. Three steps that would be very beneficial if taken by our state association are as follows:

1. Establish a guide for hospital medical staff organization. This service would be very helpful, both in developing a medical staff organization, as well as in improving an established organization.

2. Employ a physician to act as a consultant to medical staffs and hospitals in developing and improving their plan of medical staff organization.

3. Provide assistance to medical staffs and hospitals in setting up a plan of medical auditing to determine the level of professional proficiency of physicians, individually and as a group, in their hospital work.

The medical audit is a fair method for physicians to use in appraising their work in order to improve their standards of patient care. It also provides an objective measure for governing boards to use in approving medical staff appointments. We feel that the medical audit should be undertaken by the medical staff itself.

I thank the program committee for the privilege of giving this report and making these related remarks. For the members of the Hospital Licensing Council, I appreciate your cooperation during this most trying period of its life. We beg of you understanding and patience. We solicit your help and suggestions. With increased effort on the part of us all, Indiana will be used as a model by the rest of the states in completing its hospital licensing programs.

AS A PRIVATE PHYSICIAN SEES PUBLIC HEALTH*†

Donald L. Lashley, M.D.

TELL CITY

PUBLIC HEALTH is a monotonous subject. There is little that appears spectacular to the average individual. I suppose we should talk about *public illness*—a much broader subject. All doctors realize after a few years of practice, that quite contrary to their thoughts on the matter when they left internship to cure the world, they were in reality working away at a huge backlog of illness, much like a lone forester trying to clear away a wilderness that grows as fast or faster than his axe will cut. No doctor, dealing as he must with each individual in his illness, has not had moments of utopian desire to clear this wilderness of disease and illness in one fell swoop.

Medical history is rich with the stories of the conquest of disease after disease, of large areas like our own malarial Southland opened for habitation by the success of medical adventure. Indeed the life span of a child may now be reckoned at 65 years, whereas a few generations back one did well to live to 40 or 45 years of age. We are rapidly getting down to the fine points as far as *length* of life is concerned.

What we most desire now is to decrease the amount of illness and increase the amount of happy productive life. I know of no better or sounder method of promoting this ideal of public health than through education of the public in the art of self-defense against our great enemy—public illness. The doctors of this county, now as in the past, stand ready to guide all such efforts and lend encouragement to the establishment of local health departments that will reach out to help educate each individual in this fine art of self-defense. The public is not entirely ignorant of the art. In recent years the stories of such enemies as cancer, tuberculosis, diabetes, rheumatic fever, malaria, polio, syphilis, appendicitis, and a host of others have been laid before its eyes. But people are busy and have to be reminded by a constant barrage of facts, and they have to be protected against the inroads of these and other causes of illness.

If we ever get a local full-time department, I hope we get a good one. The local health officer would have to be a pioneer with the enthusiasm of a Don Quixote, the soft voice of a master diplomat, and the sternness of a dictator, plus the wisdom of a Solomon. He would have to have nose trouble and get his nose into every crook and cranny, discover all the worst places to eat, and the dirtiest cooks and waitresses, help the county agent ferret out all diseased cattle, chase down all the venereal disease, help isolate tuberculosis patients from the community, discover the neighborhoods where filth and unsanitary conditions prevail, know the garbage man intimately, study the topography of open drainage ditches and water sheds, help devise methods of improving working conditions in our factories, help our teachers teach public health, take movies, run a movie projector on local disease traps, show health films every place he could erect a screen, advise the administration about housing conditions and swimming holes, serve as ambassador for the medical profession and health department at all county meetings including 4-H Clubs, Farm Bureau, Grange, dairy raisers meetings, conduct food handlers' schools, and plug for Grade A milk. He would literally be a busy guy with a bloody nose. If we can get that poor fellow for what money we would have to pay him, we'd feel like cheaters at the beginning. But after a few years, his job would be easier, and our hope is that some of the expenses and misery of illness in this county would be lighter.

Since neither state nor federal assistance will benefit our community without the initiative being taken locally, it would appear extremely desirable for community leaders to be aware of these future possibilities so that the necessary petitions for a referendum could be secured before the general election in November, 1950, *providing they should decide that a full-time health department is the possible answer to our particular problems.*

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* Given at the Tell City Health Conference October 24, 1949.

† Excerpts from an article in the December 1949 issue of the *Monthly Bulletin* of the Indiana State Board of Health.

News Notes

The Indiana Academy of General Practice will hold its annual scientific and business program on April 19 at the Indiana University Medical Center in Indianapolis. The program will include morning clinics from 9:00 to 12:00 a.m., with lunch at the Center, an afternoon business and scientific program, and an evening dinner meeting at the Indianapolis Athletic Club. Wives are invited to attend the dinner. Further information pertaining to the program will apper in the April JOURNAL. The speaker for the evening will be Dr. Philip Thorek, of Chicago, and since the evening meeting will be held in conjunction with the meeting of the Indianapolis Medical Society, it is suggested that reservations be made early. Reservation blanks will be mailed shortly.

The American Goiter Association will meet at the Shamrock Hotel, in Houston, Texas, March 9, 10 and 11. The three-day meeting will consist of papers dealing with goiters and other diseases of the thyroid gland, dry clinics and demonstrations. For further information, address George C. Shivers, M.D., Colorado Springs, Colo.

The **Indiana Neuropsychiatric Association** has announced that **Dr. Leo Bartemeier**, president-elect of the American Psychiatric Association, will be its guest on May 29, and will speak on "The Psychology of Disturbances of Sleep."

INDUSTRIAL HEALTH CONFERENCE

The 35th annual meeting of the American Association of Industrial Physicians and Surgeons and four other industrial associations will be held in the Sherman Hotel in Chicago, April 22-29. More than 100 papers will be read during the eight-day meeting.

The Association's convention is held concurrently with four other groups—The American Industrial Hygiene Association, The American Conference of Governmental Industrial Hygienists, The American Association of Industrial Nurses, and the American Association of Industrial Dentists.

NORTHERN TRI-STATE POST GRADUATE MEETING

The seventy-seventh annual meeting of the Northern Tri-State Post Graduate Medical Association will be held on April 11 at the Pantlind Hotel in Grand Rapids, Michigan. Speakers for the morning will be: Honorable Stanley J. David, Mayor of Grand Rapids; W. H. Gordon, M.D., of Detroit; A. P. R. James, M.D., of Toledo; Paul C. Bucy, M.D., of Chicago; G. De Takats, M.D., of Chicago; Vincent J. O'Connor, M.D., of Chicago; and F. Hartman, M.D., of Detroit.

Dr. Paul R. Hawley, director of the American College of Surgeons, will be the luncheon speaker, and he will be followed by: Frederick F. Yonkman, M.D., Summit, N. J.; R. Isaacs, M.D., Ann Arbor; J. H. Warvel, M.D., Indianapolis; and J. L. Wilson, M.D., Ann Arbor.

The **Alembert Winthrop Brayton Skin and Cancer Foundation** will feature Dr. R. L. Mayer, director of Laboratories of Microbiology, Ciba Pharmaceutical Corporation, of Summit, New Jersey, at its meeting at Indianapolis General Hospital on April 13. This will not be a clinical meeting, but instead, there will be three or four lecture sessions, spaced throughout the day, the first one beginning at 9:30 a.m. Subjects pertaining to dermatology, pharmacology, the anti-histamines, and immunology will be discussed.

POSTGRADUATE COURSE ON GENERAL SURGERY

"Practical Problems in General Surgery" is the subject of a continuation course to be presented on April 6, 7, and 8 by the Frank E. Bunts Institute and the Cleveland Clinic. On Friday evening, April 7, Dr. Daniel C. Elkin of Emory University, Dr. Claude Beck of Western Reserve University Medical School, and Dr. R. B. Turnbull of the Cleveland Clinic will take part in a symposium on "Vascular Surgery." On Saturday morning, April 8, Dr. George G. Finney of Johns Hopkins University and others will present Panel Discussions on surgery of the colon, pancreas, biliary tract, and stomach and duodenum.

Inquiries regarding the complete program and registration can be addressed to the Director of Education, Frank E. Bunts Educational Institute, 2020 East Ninety-third Street, Cleveland 6, Ohio.

Dr. Cleon A. Nafe, of Indianapolis, was reelected to the executive committee of the National Conference on Medical Service of the A.M.A., at its meeting on February 5 in Chicago. Doctor Nafe is a past president of this Conference.

Dr. Murray E. Harden, of Covington, has announced the opening of his office for the practice of obstetrics and gynecology at 20 North 24th Street, in LaFayette. Doctor Harden graduated from Indiana University School of Medicine in 1941 and interned at Indianapolis General Hospital. He spent forty-five months on active duty with the Army in World War II. Following his release from service, he spent three years as resident in obstetrics and gynecology at Indianapolis General Hospital.

After twenty-five years of practice in Three Rivers, Michigan, **Dr. Dale C. Weir** has returned to LaGrange to continue practice. Resolutions honoring his work and activity as a member of the St. Joseph County Medical Society at Three Rivers were forwarded to him.

Dr. Walter Hollis, a graduate of Indiana University School of Medicine and resident at Indianapolis General Hospital, has purchased the residence of the late Dr. B. C. Gwaltney and will open an office in Fort Branch.

Dr. William T. Sallee of Indianapolis has purchased the office and equipment of the late Dr. I. M. Sanders at Greensburg and expects to locate there by mid-summer. He is serving an internship at St. Vincent's Hospital, Indianapolis, after graduating from a medical school in Philadelphia.

Dr. Charles M. Bowman and **Dr. Justin R. Nash** recently opened a new medical building in Albion, known as the Albion Clinic.

Announcement is made by **Dr. Theodore D. Arlook** of the opening of an office at 912 Franklin Street, Elkhart, where he will specialize in the treatment of skin diseases. Before service in the army during the war he had been a general practitioner in Elkhart.

Dr. Robert L. Armington has succeeded **Dr. W. L. Sharp** as a member of the Anderson city health board, and secretary of the agency.

A new clinic group has been established at Madison by **Drs. Lewis E. Jolly, Robert O. Zink, Jackson W. Modisett** and **Marcella S. Modisett. Dr. Schuyler A. Whitsett** has office quarters there and **Dr. Edgar S. Weaver** of Carrolton, Kentucky, will maintain part-time hours for x-ray work.

Dr. Dwight W. Schuster is now associated with **Dr. Murray DeArmond**, at 723 Hume Mansur Building, Indianapolis, in the practice of neuropsychiatry. A 1944 graduate of the Indiana University School of Medicine, Doctor Schuster spent two years in the army, and recently completed his residency at Norways Sanitarium in Indianapolis.

A 1944 graduate of Indiana University School of Medicine, **Dr. Alfred T. Symmes** has opened an office for the practice of internal medicine at 605 East Maple Road, in Indianapolis. Doctor Symmes is a veteran of World War II, and he has had three years of postgraduate work.

Dr. Floyd W. Mohler, who has been in practice in Indianapolis, has gone to South Bend for a year's residency in the Northern Indiana Hospital for Children. He is a 1944 graduate of Indiana University School of Medicine, and spent two years in service.

A 1941 graduate of Indiana University School of Medicine, **Dr. Herbert L. Joseph** is now in the practice of dermato-syphilology at 607 Carolina Street, Vallejo, California. Doctor Joseph took postgraduate work at the Barnard Free Skin and Cancer Clinic, and then spent more than three years in service as a flight surgeon.

Dr. Thomas V. Reese, formerly of Indianapolis, has opened an office for the general practice of medicine at 307 Haberfelde Building, in Bakersfield, California. Doctor Reese graduated from Indiana University School of Medicine in 1946, and is an air corps veteran.

Dr. Ward Laramore is now in practice of internal medicine and cardiology at LaPorte. He is a 1942 graduate of Indiana University School of Medicine, a veteran of World War II, and formerly was a full-time physician with the VA hospital at Billings.

Dr. Ray Henn will assist in the practice of medicine and surgery at Luckey Hospital in Wolf Lake. He graduated from Indiana University School of Medicine in 1946, served his internship at Indianapolis General Hospital, was resident in surgery at U. S. Naval Hospital in Oakland, California, and later served as medical officer on a naval transport for dependents.

An office has been opened in South Bend for the general practice of medicine by **Dr. Joseph Spyridon Stratigos**. He served as captain in the medical corps for two years and has completed a year as resident physician at Memorial Hospital in South Bend.

Dr. Duke E. Hanna has located in a new office at Red Key. A graduate of Indiana University School of Medicine, he interned at Indianapolis General Hospital and later was in the Navy, being stationed at Long Beach, California and Hawthorne, Nevada.

Offices have been opened by **Dr. Irving Cohen** in the same building with **Dr. Alan Johnston** in Plainfield, sharing a reception room. Doctor Cohen graduated from the University of Toronto.

Dr. T. P. Walsh of Garrett, has sold his interest in the Garrett Clinic to **Drs. L. A. Jinnings** and **F. B. Kantzer**, and is moving to Fort Worth, Texas, where he has accepted a position with the Coffey Clinic.

Dr. Joseph F. Ferrara has moved from Indianapolis to Franklin, where he is specializing in surgery. A graduate of the Indiana University School of Medicine in 1941, he served for more than three years as a major in the army.

Dr. Thomas O. Middleton has opened an office at 404 East Seventh street, Bloomington, for the practice of pediatrics. He graduated from Indiana University School of Medicine in 1942, served as a flight surgeon for three years, and practiced at Mitchell for one and one-half years before serving at the Children's Hospital at the University of Pittsburgh Medical Center for two years.

Dr. M. G. Meyer, of Michigan City, and **Dr. Hugh A. Kuhn**, of Hammond, read papers before the American College of Allergists, at the annual meeting held in St. Louis in January.

After two years of residency at Mayo Clinic, **Dr. Chester A. Stayton, Jr.** has become associated with his father, **Dr. Chester A. Stayton, Sr.**, and **Dr. James C. Katterjohn** in the practice of radiology at 313 Hume Mansur Building, Indianapolis.

Dr. John A. Crawford, a graduate of Indiana University School of Medicine in 1942, and who served for thirty months as a transport surgeon, has become associated with **Dr. Frank W. Teague** at 501 Hume Mansur Building, Indianapolis, in the practice of orthopedics.

Specializing in the practice of internal medicine, **Dr. Robert B. Failey** is now located at 420 Hume Mansur Building, Indianapolis. He is a graduate of the Harvard Medical School, in 1943.

Dr. G. J. Nassef, after several months in Plymouth, has opened an office in Walkerton. He is a graduate of Jefferson Medical School, Philadelphia, and interned at St. Luke's Hospital, Bethlehem, Pennsylvania.

Dr. Cecil Patterson has opened offices for the general practice of medicine at Charleston.

Dr. G. E. McCoy has opened an office at 417 Wysor Building, in Muncie, limiting his practice to pediatrics.

Dr. Roger E. Lingeman, of Eaton, has opened an office for general practice at 4153 Boulevard Place, Indianapolis. He graduated from Indiana University School of Medicine in 1943 and spent two years in army service.

Tipton Clinic has been opened by **Dr. Boyd A. Burkhardt** and **Dr. William A. Kurtz** and their staff at South West and West Madison streets, in Tipton. Members of Tipton County Medical Society and their wives and members of the staff of Mercy Hospital, Elwood, were guests at the formal opening on January 29.

The new Veterans Administration Hospital at Fort Wayne will be headed by **Dr. Russell Hiatt**, assistant area medical director at Washington, D.C., and previously with the Chicago VA area, having jurisdiction over Wisconsin, Illinois and Indiana. He is a native of Sheridan, and after graduating from Indiana University School of Medicine he had been associated with his father, **Dr. J. E. Hiatt**, practicing in New Castle and Richmond before serving in the army medical corps during the war.

The Board of Regents of the **American College of Chest Physicians** offers a cash prize award of $250 to be given annually for the best original contribution, preferably by a young investigator, on any phase relating to chest disease.

Information may be obtained from the Executive Secretary of the College, 500 North Dearborn Street, Chicago 10, Illinois.

Candidates for the certificate of the **American Board of Ophthalmology** are accepted for examination on the evidence of a written qualifying test. These tests are held anually in various parts of the United States.

Applications are now being accepted for the 1951 written test. They will be considered in order of receipt until the quota is filled.

Practical Examination for Acceptable Candidates 1950

Boston	May 22-26
Chicago	Oct. 2-6
West Coast	January, 1951

For further information contact Dr. Edwin B. Dunphy, Secretary - Treasurer, Executive Office, Cape Cottage, Maine.

PROFESSIONAL ILLUSTRATORS AND PHOTOGRAPHERS

The Academy-International of Medicine is establishing an information service on professionally trained medical illustrators and photographers who will assist the profession in the preparation of all types of papers for publication, meetings, visual demonstrations and exhibit material. Information on illustrators and photographers is to be available, upon request, to the entire profession. All doctors having personal knowledge of competent illustrators or photographers are requested to assist by providing the technicians names and addresses. Send information to: Academy-International of Medicine, 214 West Sixth Street, Topeka, Kansas.

JOBS FOR CARDIAC WORKERS

A plea to the nation's employers to provide suitable jobs for workers with heart ailments has been made by Secretary of Labor Maurice J. Tobin, who is Labor Chairman of the 1950 Heart Campaign, and Dr. H. M. Marvin, President of the American Heart Association.

In commenting on the responsibility of employers in dealing with the heart disease problem, Secretary Tobin said:

"We have to convince employers that it makes sense to hire workers with heart ailments, if they are suitably placed. There must be proper facilities for determining just what job is most suitable to the employe with heart disease. We have to develop the right kind of rehabilitation and vocational training programs for these people."

Dr. Marvin, who is Associate Clinical Professor of Medicine at Yale Medical School, pointed out that, while heart deaths lead all others in this country, both death and disability from this cause can be reduced "by making better use of the knowledge we already have."

"Many persons can go on working despite a heart ailment, and without damaging their health," Dr. Marvin said, "if their condition is accurately diagnosed and they are given suitable work."

Under the terms of legislation enacted by Congress in 1949, each state is now permitted to fix the share of Federal aid under the Hospital Survey and Construction Act either on the basis of a fixed percentage for all construction within the state or on a variable percentage between fixed limits, with a maximum of 66⅔ percent.

Forty-two states have chosen the fixed rate of Federal aid, with an average for all fixed percentage states of 47 percent. Only Florida, Massachusetts, Michigan and New Mexico have adopted the variable scale. Indiana has chosen a fixed rate of 50 percent.

The new address of the **Indiana State Board of Health** is 1330 West Michigan Street, Indianapolis. They began moving into their new quarters on February 15, and extend an invitation to everyone to visit them in their new quarters.

EXAMINATION FOR MEDICAL OFFICERS

A competitive examination for appointment of Medical Officers in the regular corps of the United States Public Health Service will be held on May 15, 16 and 17. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received no later than April 17. Address the Public Health Service, Federal Security Agency, Washington 25, D.C.

OXYHEMOGRAPH

Of interest to the medical profession is the announcement by Photocon Research Products of its new "Oxyhemograph," an instrument that continually records the oxygen saturation of the blood.

The Oxyhemograph should prove useful in studies of all conditions which may be related to anoxemia and anoxia. According to Photocon, the Oxyhemograph makes possible the study of varied problems in physiology and medicine which deals with the oxygenation of the blood. It has already proved valuable in anesthesia studies, both clinical and experimental, and in aviation research.

The Oxyhemograph was developed through the joint efforts of the staffs of Henry Ford Hospital, the Research Laboratories Division of General Motors Corporation and Photocon Research Products.

Light from a lamp in the ear unit is transmitted through the ear and strikes a photocell which in turn generates an electrical signal. This signal is amplified to actuate a recording milliameter. The position of the pointer on the recorder is indicative of the percent of oxygen saturation of the blood under the prevailing conditions. The photocell in the ear unit and the electrical control circuits is constructed in such a manner that volume variations in blood are cancelled, leaving only the changes due to a shift in the degree of oxygenation of the blood.

Clinical data shows the Oxyhemograph to be stable and accurate. The first warning of developing anoxemia is registered much earlier than can be appreciated by clinical observations, because the slightest change in transparency of hemoglobin is registered immediately.

Further Oxyhemograph data may be obtained by writing Photocon Research Products, 1062 North Allen Avenue, Pasadena 7, California.

A.M.A. WASHINGTON OFFICE NEWS

A.M.A. WASHINGTON OFFICE IN NEW LOCATION

The A.M.A. Washington office moved to larger quarters on March 1. The Washington office is now located in Rooms 300 to 312 at 1523 L Street, N.W., which is in the immediate vicinity of the Statler Hotel. The A.M.A. has taken over the entire third floor of the building on a five year lease.

Social Security Amendment Hearings before the Senate Finance Committee are the center of interest in Washington at the present time. Last week in CAPITOL CLINIC we called attention to the fact that hearings were being held Mondays through Saturdays from 10 o'clock until noon. However, due to a heavy demand from many persons who wish to testify, the tempo has been stepped up and afternoon sessions were scheduled beginning January 23rd from 2 until 5:30 P.M. A list of witnesses for the ensuing week has been available on Thursdays and for the past several weeks we have included such lists with our bulletins. To date very little attention has been given by witnesses to that section of the bill providing insurance against permanent and total disability. Generally speaking, witnesses from the south and southwest are arguing for increased coverage of old-age security insurance to include the farmers, while witnesses from the north and east are more interested in public assistance.

The Brookings Institution on January 24th issued a timely study seriously questioning the financial soundness of the social security program and the Administration's proposals to expand it. The study points out that the full benefit load will not materialize for approximately 50 years and by that time benefit payments would increase to between 13.2 and 20.6 billions of dollars a year without including cost estimates for temporary insurance recommended by the Administration. If compulsory health insurance were added the cost would be increased from 26 to 46 billion dollars a year. If public assistance and veterans' benefits analogous to social security payments are included, the aggregate cost is estimated at between 33 and 55 billions. The study further points out that to carry such a program would require a much larger economy. The study warns, "If either the burden of taxation or the availability of social security benefits is such as to lessen individual incentives the prospects for an expanding productive system will be correspondingly impaired." Copies of the study are available at $3 each and may be ordered from The Brookings Institution, 722 Jackson Place, N.W., Washington 6, D.C.

The Federal Aid to Medical Education bill before the House Interstate and Foreign Commerce Committee is again being discussed in executive sessions of the Health Subcommittee. This bill, H.R. 5940, has already been reported and is before the Rules Committee. Several meetings were held last week but there is no definite word concerning the possibility that the committee might accept A.M.A. recommended changes chiefly aimed at reducing federal control of medical education.

The School Health Services bill, S. 1411, also before the House Interstate and Foreign Commerce Committee has not been discussed this year.

Department of Defense—Paul J. Larsen, formerly associated with the Atomic Research Energy Commission was named as first chairman of the civilian mobilization office and will take over his new duties on March 1st. This office is one of eight planning groups of the National Security Resources Board. Mr. Larsen's duties will include the supervision and planning for civil defense, health resources, housing and community services; strategic dispersion of industrial and governmental facilities, and censorship. The new concept of civil defense is to place responsibility on local governments and the program will be channeled through state governments to the local authorities. It is contemplated that observation posts, filter centers, and control centers will be established.

Army—Major General R. W. Bliss, Army Surgeon General, has selected 26 civilian and 3 Army physicians to participate in an Overseas Consultant Program including seminars and clinics for overseas physicians, interclinical conferences, hospital tours, and inspection of facilities for overseas care.

The index catalog of the medical library of the Surgeon General's Office is being revised in keeping with modern medical indexing requirements. When the work is completed it is planned that a volume will be published that will make the record of its monographic holdings complete through 1949.

The American Legion National Commander George N. Craig on January 27, speaking before the Women's Patriotic Conference on National Defense, at the Statler Hotel in Washington, D.C., urged the establishment of an Armed Forces school of medicine to train men selected competitively from the military services for medical careers. This would raise the quality and stature of medicine within the Armed Forces, making possible more efficient and more economical care of the health of those in uniform, he said. It would relieve the Defense Department of the necessity of competing with private medicine for a supply of doctors.

NEW BILLS INTRODUCED

S. 2940 National Health Act—By Mr. Hunt, of Wyoming, January 30.

To consolidate the health activities of the Government, to provide a program of national health insurance in order to make available to low-income groups medical services of the highest possible quality and in the greatest possible volume, and for other purposes.

Referred to the Committee on Labor and Public Welfare.

Comment: TITLE I—New department created. Would establish an executive department known as the Department of Health. The Secretary (member of the President's Cabinet) and the Under Secretary would be professional health workers with experience as practicing physicians or dentists. Four assistant secretaries experienced in the field of medicine, dentistry, sanitary engineering, or public health, would be appointed, and the fifth, the Assistant Secretary for Staff Services, would be experienced in administrative management. (None may have held office in a political party.) A special advisory board would assist the Secretary of Health and be composed of the Chief of the Office of Medical Services in the Department of Defense, the Federal Security Administrator, and the Administrator of Veterans' Affairs. The organization of the department would include a Bureau of Medical and Hospital Care, a Bureau of Public Health Practice, a Bureau of Children's Health, a Bureau of Research, and a Bureau of Staff Services. The duties of the new department would include all the health activities of the present Federal Security Agency; promotion of more adequate local public health and medical- and hospital-care services in shortage areas, including the training of health and related personnel; administering a national medical-care program; increasing the use of nongovernment, private, and university physicians and dentists in providing care for Federal beneficiaries; improved planning and operation of Federal hospitals and the medical- and dental-care services therein to insure better integration with civilian hospitals and civilian medical and dental services; coordinating the Government's health care, public health, and health research activities; encouraging cooperation by units of the Department of Health with voluntary health agencies; promoting better civilian and medical care preparedness for defense; improving the coordination between military and nonmilitary medical and mental programs of the Government and cooperating in providing freer exchange of personnel between military and nonmilitary services; development of more centralized planning of nonmilitary medical and health programs of the Government; and furnishing the President and his Cabinet with information and assistance on vital problems in mental health and mental attitudes with reference to world cooperation for health and peace.

INDIANA UNIVERSITY NEWS NOTES

Opportunity for a review of developments in the diagnosis of cancer and the management of malignant disease will again be brought to physicians and dentists through a two-day postgraduate course at the Indiana University Medical Center on Wednesday and Thursday, April 12-13.

While the list of speakers for the sessions has not been completed, leaders in the various fields concerned with cancer will participate in the program of lectures and clinics. The program is designed to be of practicable value to the practicing physicians and dentists. The course is beng presented jointly by the Indiana University Schools of Medicine and Dentistry with the support of the Indiana Cancer Society.

The course will open with a joint session for physicians and dentists in the auditorium of the School of Medicine. In the afternoon a special program for dentists will be held at the School of Dentistry while the physicians will continue their program during the afternoon and evening at the Medical School, returning there Thursday for morning and afternoon sessions.

No advance registration is required and there are no fees in connection with the cancer course.

BE SURE YOU ARE ELIGIBLE TO VOTE IN THE MAY 2 PRIMARY

The right to vote is not only a privilege of American citizenship—it is a duty. The election this year is the most important in the nation's history, from the physicians' standpoint. It is, therefore, the solemn obligation of every doctor, his wife, and all eligible members of his family to register and vote.

The final day to register for the May 2 primary election is Monday, April 3. If you are in doubt about your eligibility to vote, check your status at your county clerk's office.

Deaths

Edmund Michael Van Buskirk, M.D., of Fort Wayne, who served as president of the Indiana State Medical Association in 1939, died on January 18, at the age of seventy-four. Although he had been ill for approximately three years, he had continued his professional duties until several days before his death.

Doctor Van Buskirk had always been active in association affairs. In 1909-1910 he served as first vice-president; from 1930 to 1937 he served as councilor of the thirteenth district; in 1936 he was vice-chairman of the Section on Medicine, and in 1937 he was chairman of that section; in 1938 he was president-elect of the association, and was a member of the Executive Committee and the Committee on Budget; in 1939, in addition to serving as president, he was a member of the Executive Committee, the Committee on Budget, the Committee on Indiana Inter-Professional Health Council, (ex-officio), and the Liaison Committee with the Indiana State Department of Public Welfare; in 1940 he was a member of the Committee on Budget and the Committee on Indiana Inter-Professional Health Council; in 1945 and 1946 he was a member of the Committee on Control of Cancer.

Doctor Van Buskirk graduated from the Fort Wayne College of Medicine in 1902, and had practiced in Fort Wayne since that time. He was a veteran of World War I, and was a member of the Fort Wayne Medical Society, and the Indiana State Medical Association, and was a fellow of the American Medical Association.

The following memorium was adopted by his county medical society:

The Fort Wayne Medical Society records with profound sorrow the passing unto his eternal rest of its cherished and revered member, Edmund M. Van Buskirk.

In his professional life he exemplified the typical American physician who, by his own efforts, continually strove to learn and augment his knowledge in order to be able always to render the best possible medical service to his patients and to the many physicians who sought his expert help. His capacity to develop and enhance his ability in his chosen specialty led him to be recognized not only locally and state-wide but nationally as a specialist of exceptional skill.

His interest in public health and organized medicine was so keen and sincere that although busily occupied practicing his specialty he devoted part of his time to these activities, with service in the local and State Boards of Health, as president of the Fort Wayne and Indiana State Medical Societies and of the Methodist Hospital staff.

His devotion to and love of his country impelled him to serve it in the emergency of war. When his country needed him he answered the call promptly and nobly, although he could have claimed exemption, and served on active duty in the United States Army as long as his services were needed.

His sense of fairness in his relationship with his colleagues, his patients, and with whomever he came in contact professionally or socially, endeared him to all who were privileged to come within his orbit. He contributed something to their lives which they will miss; they realize that they have sustained an irreparable loss.

* * *

Herbert Franklin Thurston, M.D., of Indianapolis, died on February 8, after a long illness. He was fifty-seven years of age. Doctor Thurston was a graduate of Rush Medical College, in Chicago, in 1924, and had specialized in surgery. He was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a fellow of the American Medical Association.

* * *

Ezra Edward Geisel, M.D., formerly of Gary, died in Tucson, Arizona on January 23, at the age of seventy-one. He was a graduate of the University of Illinois College of Medicine in 1903, and was a member of the Lake County Medical Society, Indiana State Medical Association and American Medical Association. He had practiced in Gary until two years ago when he moved to Tucson.

* * *

Orville Adam DeLong, M.D., of Elizabethtown, died in Columbus January 29 at the age of eighty-two, after two weeks illness. He was a graduate of the Physio-Medical College of Indiana at Indianapolis in 1891, and was a member of the Bartholomew County Medical Society, the Indiana State Medical Association and American Medical Association.

* * *

Frank George McCarthy, M.D., of Terre Haute, died suddenly on January 21, at the age of sixty-eight. He was a graduate of the Indiana University School of Medicine at Indianapolis in 1909, and was a member of the Vigo County Medical Society, Indiana State Medical Association, and a fellow of the American Medical Association.

Mr. Murray Auerbach, executive secretary of the Indiana Tuberculosis Association, died suddenly on January 15, in Indianapolis, a short time before his scheduled departure on a trip to attend a meeting of the state executive secretaries of tuberculosis associations. The medical profession of Indiana thereby suffered the loss of a loyal and indefatigable colleague and good friend. A resolution on his passing by the Indiana State Tuberculosis Association is reproduced below:

RESOLUTION

With the passing of Murray A. Auerbach, Indiana has lost a great leader in public health work and the county, state and national tuberculosis associations have lost a strong counselor and director of the fight against tuberculosis.

A native of New York City, Mr. Auerbach attended New York University. He continued his education at the New York School of Social Work, now a part of Columbia University. Following a brief period as a reporter for the New York Times, he became executive secretary of the Erie County Tuberculosis Association, (Pa.) in 1909. Two years later, he organized the Arkansas Tuberculosis Association. After a period of service in World War I, during which he enlisted at the age of 36 and became a lieutenant in the Sanitary Corps, Mr. Auerbach was mustered out and was appointed regional secretary of the National Tuberculosis Association, with headquarters at Atlanta, Georgia.

On September 26, 1920, he became executive secretary of the Indiana Tuberculosis Association. Mr. Auerbach also served as executive secretary of the Indiana Trudeau Society from its inception in 1931. During the past twenty-nine years, he had devoted his life to the task of building and strengthening official and private health agencies in every county in Indiana, in the state, and in the nation. By the force of his personality and the largeness of his vision, he brought laymen and physicians together in a common cause.

As the direct result of his counsel and inspiration, county tuberculosis associations throughout Indiana expanded the scope of their work and coordinated their efforts into an effective, state-wide, tuberculosis control program.

Mr. Auerbach was largely responsible for legislation leading to construction of the state and county tuberculosis sanatoria in Indiana. He led the successful effort to establish the Indiana Tuberculosis Council.

Mr. Auerbach was the fifth person to receive the Hoyt E. Dearholt Medal, awarded annually to a member of the Mississippi Valley Conference on Tuberculosis for outstanding achievement in tuberculosis work. He received this award in 1945.

At one time or another, Mr. Auerbach served on virtually every committee of the National Conference of Tuberculosis Secretaries and of the Mississippi Valley Conference, either as a member or as chairman. He was a past president of the Mississippi Valley Conference. While serving as a member of the Committee on Administrative Practice of the National Conference of Tuberculosis Secretaries, he wrote two of a set of five pamphlets known as the "Administrative Series." Also, he was the author of many articles and pamphlets on subjects relating to tuberculosis and health. These works stand as a permanent record of his creative thinking.

Besides his interest in tuberculosis work, he was an active leader in the wider field of public health. He was the first president of the Indiana Public Health Association and, from its inception, was secretary of the Indiana Health Council. In addition, he was a member of the Executive Committee of the Indianapolis Council of Social Agencies and was a member of the Planning Committee of its Health Section. In November, 1949, he was appointed by Governor Schricker to the newly-established Indiana Council for Children and was named chairman of the Constitution Committee of the Council. He made many notable contributions in the field of public health.

Mr. Auerbach approached every task with wisdom and vigor, always seeing the full view of each problem. His co-workers were his friends. Through his knowledge of human nature and his ability to work with others, he left an outstanding record of accomplishment.

* * *

John Isaac Mitchell, M.D., of Salem, died January 24 at the age of sixty-nine. He was a graduate of the Hospital College of Medicine at Louisville in 1906, and was a member of the Washington County Medical Society, and Indiana State Medical Association, and was a fellow of the American Medical Association.

* * *

Whitfield Bowers, M.D., of Michigan City, died January 13 at the age of seventy-nine. He was a graduate of the Marion-Sims College of Medicine, St. Louis, in 1899.

* * *

Walter Harvey Coleman, M.D., of Evansville, died January 7 at Hopkinsville, Kentucky, at the age of seventy-two. He was a graduate of the University of Louisville School of Medicine, in 1900, and had practiced nearly fifty years in Evansville before retiring. He was a member of the Vanderburgh County Medical Society, the Indiana State Medical Association, and was a fellow of the American Medical Association. He had served in the army medical corps during the first World War.

* * *

Edward M. Glaser, M.D., of Brookville, died January 19 at the age of sixty-seven. He was a graduate of the Indiana Medical College, School of Medicine of Purdue University, Indianapolis, in 1907, and was a member of Fayette-Franklin Counties Medical Society and Indiana State Medical Association, and was a fellow of the American Medical Association.

* * *

William B. Hartsock, M.D., of Indianapolis, died December 29 at the age of seventy-one. He was a graduate of the Hospital College of Medicine, Louisville, in 1901, and had practiced in Morgan County before locating in Indianapolis about twenty years ago.

* * *

John Ellsworth Taylor, M.D., of Leopold, died January 13 at Louisville, at the age of eighty. He was a graduate of the St. Louis College of Physicians and Surgeons in 1899 and of the University of Illinois College of Medicine in 1908. He was a member of the Perry County Medical Society, the Indiana State Medical Association and the American Medical Association. All of the members of the Perry County Medical Society attended the funeral.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

January 15, 1950

The Council of the Indiana State Medical Association convened for its midwinter meeting at 10:10 A.M., Sunday, January 15, 1950, in the Harrison Room of the Columbia Club, at Indianapolis, with Dr. W. U. Kennedy, chairman, presiding.

Roll call showed the following present:

Councilors:

First District—Herman T. Combs, Evansville
Second District—William C. Reed, Bloomington
Third District—William H. Garner, New Albany
Fourth District—George A. May, Madison
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—Cyrus J. Clark, Indianapolis
Eighth District—E. H. Clauser, Muncie
Ninth District—Wemple Dodds, Crawfordsville
Tenth District—William H. Howard, Hammond
Eleventh District—Elton R. Clarke, Kokomo
Twelfth District—M. B. Catlett, Fort Wayne
Thirteenth District—Kenneth L. Olson, South Bend

Officers:

Claude S. Black, Warren, president
A. F. Weyerbacher, Indianapolis, treasurer
Frank B. Ramsey, Indianapolis, editor of THE JOURNAL
W. L. Portteus, Franklin, member of Executive Committee
Albert Stump, Indianapolis, attorney
Ray E. Smith, executive secretary
James A. Waggener, field secretary

Guests:

Cleon A. Nafe, Indianapolis, chairman, Indiana A.M.A. Campaign Coordinating Committee
William M. Cockrum, Evansville, co-chairman, Committee on Convention Arrangements, and delegate to the A.M.A.
E. Vernon Hahn, Indianapolis, chairman, Committee on Mental Health
Paul D. Crimm, Evansville, alternate councilor, First District, and chairman, Committee on Tuberculosis
Harry E. Klepinger, LaFayette, chairman, Committee on Medical Education and Hospitals

On motion of Drs. Mitchell and C. J. Clark, the minutes of the Council meetings held on September 26 and 29, 1949, were approved as printed in the November, 1949, issue of THE JOURNAL.

Reports of Councilors

District meetings were reported scheduled as follows:

1st District—Evansville, May 25
2nd District—Vincennes, ————
3rd District—Jeffersonville, ————
4th District—Greensburg, May 17
5th District—Terre Haute, May 17
6th District—Greenfield, May 24
7th District—Indianapolis, May 9
8th District—Muncie, ————
9th District—Fowler, June 1
10th District—Whiting, April 5
11th District—Marion, May 17
12th District—Fort Wayne, April 4
13th District—Michigan City, November 8

In addition, reports were given on surveys being made on the contemplated postgraduate study program and on activities in the various districts in the interest of the national educational campaign.

Reports of Officers

Dr. C. S. Black, president 1950. "So far as I know everything seems to be percolating. We had a meeting at French Lick last Thursday, in preparation for the September meeting, which I think was very successful. Doctor Cockrum will give you that report later.

"You have heard some reactions on the Grievance Committee. Read your JOURNAL. Five ex-presidents were to be appointed. They were to take up grievances. They were to come under the Public Relations Committee, and that is the reason why it was put in Public Relations. I talked with some of the men last night . . . Doctor Mericle and Doctor Denny thought it was wonderful. I have not personally talked with anyone against it. I have received a letter about naming it something else. I don't think we want to hide behind anything. Most of the men are too fearful toward that name. I am calling spades 'spades' here. We have had wonderful editorials throughout the state and in the Louisville paper. I think we can't ignore the benefits of such a committee. The public has some place to talk about its troubles."

Following Doctor Black's talk, Drs. Garner, Clauser, Portteus, May, Dodds and Reed presented their views on this subject.

Dr. A. F. Weyerbacher, treasurer, presented the following report which was compiled by George S. Olive and Company, certificed public accountants:

Treasurer's Report

January 13, 1950

The Council,
Indiana State Medical Association,
Indianapolis, Ind.

Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association as of December 31, 1949, and the statements of income and expense, and fund balances for the year

then ended, on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, subject to the comments contained in this report, the accompanying statement of assets, all funds, and related statements of income and expense, on the basis of cash received and disbursed, present fairly the position of the Indiana State Medical Association at December 31, 1949, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

GENERAL COMMENT

In exhibit A is presented an analysis of the decrease in assets of the Association for the year ended December 31, 1949, showing in summary form the sources from which this decrease was derived.

A decrease of $6,931.93 in assets of the general fund resulted from an excess of operating cash disbursements over operating cash receipts.

Exhibit C presents a comparative analysis of the cash receipts and disbursements for the years ended December 31, 1949, and December 31, 1948. Total receipts increased $19,281.20, and total disbursements increased $31,129.77 over the preceding year.

Details of the assets of all funds are presented in exhibit B. There were no recorded liabilities at December 31, 1949, and the assets shown represent the surplus of each fund at that date. We have examined securities of the Association, which are kept in the Association's safe deposit box in the Indiana National Bank. Cash on deposit was confirmed by direct correspondence with the depositories.

Analyses of the cash receipts and disbursements of the general fund, of The Journal of the Indiana State Medical Association, and of the Medical Defense fund are presented in exhibits C, D, and E, respectively.

Yours very truly,
Geo. S. Olive & Co.
Certified Public Accountants.

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Decrease in Assets, All Funds, Year Ended December 31, 1949

TOTAL ASSETS, DECEMBER 31, 1949—Exhibit B			**$72,678.56**
TOTAL ASSETS, DECEMBER 31, 1948			**80,646.23**
NET DECREASE			**$ 7,967.67**
Arising from the following sources:			
Excess of operating cash disbursements over operating cash receipts, general fund, year ended December 31, 1949:			
Receipts—			
Exhibit C	$87,159.64		
Disbursements—			
Exhibit C	94,391.57		
	7,231.93		
Increase in petty cash fund	300.00		
		$6,931.96	
Excess of operating cash disbursements over operating cash receipts, The Journal of the Indiana State Medical Association, year Ended December 31, 1949:			
Receipts—			
Exhibit D	43,676.21		
Disbursements—			
Exhibit D	44,652.95		
		976.74	
Excess of operating cash disbursements over operating cash receipts, Medical Defense fund, year ended December 31, 1949:			
Receipts—			
Exhibit E	3,041.00		
Disbursements—			
Exhibit E	3,100.00		
		59.00	
NET DECREASE			$ 7,967.67

Exhibit B

INDIANA STATE MEDICAL ASSOCIATION

Statement of Assets, All Funds, at December 31, 1949

GENERAL FUND:			
Cash on deposit——Exhibit C		$ 8,964.01	
Petty cash fund		500.00	
Investments:			
Indianapolis City Hospital Bonds	$ 5,000.00		
U. S. Treasury bonds	5,000.00		
U. S. Savings bonds	31,000.00		
		41,000.00	
Total general fund			$50,464.01
THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:			
Cash on deposit—Exhibit D			4,822.83
MEDICAL DEFENSE FUND:			
Cash on deposit—Exhibit E		2,391.72	
U. S. Treasury bonds	5,000.00		
U. S. Savings bonds	7,000.00		
U. S. Baby bonds	3,000.00		
		15,000.00	
Total Medical Defense fund			17,391.72
TOTAL ASSETS, ALL FUNDS—Exhibit A			$72,678.56

Exhibit C

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Cash Receipts and Disbursements, Years Ended December 31, 1949, and December 31, 1948

	Year Ended Dec. 31 1949	Year Ended Dec. 31, 1948	Increase (Decrease)
CASH BALANCE AT BEGINNING OF YEAR	$16,195.94	$11,579.30	$ 4,616.64
RECEIPTS:			
Membership dues	53,300.00	52,039.00	1,261.00
Income from exhibits	15,080.00	12,676.23	2,403.77
Interest income:			
U. S. Treasury bonds	212.50	212.50	------
U. S. Savings bonds	625.00	437.50	187.50
Indianapolis, Indiana, City Hospital bonds	200.00	200.00	------
Marion County, Inana, Flood Prevention bonds	127.50	127.50	------
Krannert Nurse Scholarship fund	------	800.00	(800.00)
Egbert Medical Scholarship fund	------	200.00	(200.00)
Centennial book fund	357.20	930.80	(573.60)
Instructional courses	239.94	197.83	42.11
Other refunds	------	57.08	(57.08)
A.M.A. campaign fund	17,000.00	------	17,000.00
Checks written off	17.50	------	17.50
	87,159.64	67,878.44	19,281.20
BEGINNING BALANCE PLUS CASH RECEIPT	103,355.58	79,457.74	23,897.84
DISBURSEMENTS:			
Transfer of applicable portion of dues to The Journal of The Indiana State Medical Association—Exhibit D	11,213.00	10,970.00	243.00
Permanent transfer of funds to The Journal	3,000.00	------	3,000.00
Medical Defense fund —Exhibit E	2,691.00	2,630.25	60.75
Purchase of securities	------	10,000.00	(10,000.00)
Headquarters office expense	26,837.25	16,792.58	10,044.67
Publicity committee	1,068.44	1,361.00	(292.56)
Public policy	2,265.62	1,483.26	782.36
Council	1,076.55	1,750.79	(674.24)
Officers	3,538.79	639.33	2,899.46
Annual session	17,865.81	7,867.28	9,998.53
Miscellaneous committees	14,363.03	7,386.90	6,976.13
Federal insurance contributions	139.63	81.88	57.75
Indiana unemployment compensation and excise tax	483.38	------	483.38
Postgraduate study	------	456.04	(456.04)
Refunds of dues	------	12.00	(12.00)
Refunds on exhibit rent	------	181.25	(181.25)
Fifty-Year Club	176.91	234.67	(57.76)
Increase in petty cash fund	300.00	------	300.00
Women's Auxiliary to the I.S.M.A.	800.00	800.00	------
Indiana A.M.A. Campaign Coordinating Committee	8,511.55	------	8,511.55
General practitioner award	60.61	61.01	(.40)
Instructional courses	------	2.00	(2.00)
Field secretary	------	551.56	(551.56)
	94,391.57	63,261.80	31,129.77
CASH BALANCE AT END OF YEAR	$ 8,964.01	$16,195.94	$(7,231.93)

Exhibit D

INDIANA STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Year Ended December 31, 1949

The Journal of The Indiana State Medical Association

BALANCE JANUARY 1, 1949		$ 5,799.57
RECEIPTS:		
Subscriptions — members — Exhibit C	$11,213.00	
Subscriptions—non-members	496.00	
Permanent transfer of funds from General Fund	3,000.00	
Advertising	27,790.33	
Collections on accounts receivable	357.09	
Single copy sales	154.50	
Electrotypes	584.81	
Miscellaneous	80.48	
Total receipts—exhibit A		43,676.21
		49,475.78
DISBURSEMENTS		
Salaries	11,534.63	
Printing	28,572.41	
Office postage	157.71	
Journal postage	636.05	
Advertising commissions	186.60	
Electrotypes	1,420.17	
Press clippings	60.13	
Editor and editorial board expense	266.07	
Office supplies	272.18	
Rent	480.00	
Electricity	32.87	
Telephone and Telegraph	207.42	
Federal insurance contributions	97.21	
Insurance	316.00	
Indiana Unemployment compensation and excise tax	231.19	
Miscellaneous	182.31	
Total Disbursements—Exhibit A		44,652.95
BALANCE, DECEMBER 31, 1949 —Exhibit B		$ 4,822.83

Exhibit E

INDIANA STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Year Ended December 31, 1949

Medical Defense Fund

BALANCE, JANUARY 1, 1949		$ 2,450.72
RECEIPTS:		
Transfer of applicable portion of dues from the general fund—Exhibit C	$ 2,691.00	

Interest income:			
U. S. Treasury bonds	$140.00		
U. S. Savings bonds	125.00		
Marion County Flood Prevention bonds	85.00		
		350.00	
Total receipts—Exhibit A			3,041.00
			5,491.72
DISBURSEMENTS:			
Malpractice fees		1,262.50	
Attorney fees		1,800.00	
Treasurers bond		37.50	
Total disbursements—Exhibit A			3,100.00
BALANCE, DECEMBER 31, 1949—Exhibit B			$ 2,391.72

On motion of Drs. C. J. Clark and Mitchell, the treasurer's report was accepted.

Dr. Frank B. Ramsey, editor of THE JOURNAL. "I am glad to report to you that the finances of THE JOURNAL appear to be in better shape this year than last year. The Cooperative Medical Advertising Bureau of the A.M.A. thinks that advertising in medical journals should be close in 1950 to what it was in 1949. I want to give Mr. Smith credit for negotiating a new printing contract with Pauleys. There is quite an advantage in not changing our printers. The new contract is considerably less in price for the printing. We have selected a new type of paper which I think is better. It is not as glossy as we have used in the past but it is the same weight of paper. We are saving $75.00 on each issue on the paper alone. These two things, together with the fact that we are holding down the number of pages this year, will enable us to come out under our budget this year."

On motion of Drs. C. J. Clark and Mitchell, this report was accepted.

Dr. W. L. Portteus, acting chairman, Executive Committee, presented the following matters for consideration of the Council:

1. *Waiver of payment of state dues.* Doctor Portteus said that requests had been received from the secretaries of three county medical societies for waiver of payment of state dues of physicians who are incapacitated due to illness but who, because they are not yet 75 years of age, cannot qualify for senior membership in the association. "I believe the A.M.A. is leaving it up to the local county medical societies to make the decision as to who are unable to pay their dues."

Doctor Mitchell said, "I think the A.M.A. tried to get around this thing of two-thirds doing the work and paying the bill and wanted to get everybody to do it. As a result, I don't think we can do anything about this."

Doctor Kennedy suggested that it might be desirable for the Council to recommend that the matter be presented to the House of Delegates for consideration at its next meeting.

Doctor Mitchell proposed that the matter be given some thought and be brought up again at the April meeting of the Council, and this suggestion was accepted.

2. *Proposal of the Disability Income Insurance Company.* The Council took no action on the proposal of this company that standards of approval for disability insurance be set.

Unfinished Business

Indiana A.M.A. Campaign Coordinating Committee. Doctor Nafe, chairman, and the field secretary reported in detail on the activities of this committee and asked that a budget of $60,000 be allowed for 1950. Doctor Nafe said, "We feel that this campaign is what the $20.00 additional dues was voted for. We think this year is the crucial year. I think the doctors of the state expect us to spend some money on this campaign." On motion of Drs. Mitchell and Combs, the Council allowed this budget request.

1949 Annual Session at Indianapolis

Appreciation of Indiana Academy of General Practice. The executive secretary read a letter from Dr. Norman R. Booher, secretary of the Indiana Academy of General Practice, expressing the appreciation of the Academy for the courtesies extended to it during the centennial session of the association.

Suggestions and Proposals for 1950 Annual Session at French Lick

1. *Dates set by Executive Committee*—Monday, Tuesday and Wednesday, September 25, 26 and 27, 1950.

2. *Report of Committee on Convention Arrangements.* Doctor Cockrum, co-chairman, presented a detailed report covering the following points:

(a) *X-ray unit.* The committee has the offer of the Vanderburgh County Mobile X-ray Unit to bring the unit from Evansville, station it outside the hotel on Tuesday and Wednesday, and make chest films for all guests who so desire, at no cost to the state medical association. On motion of Drs. Mitchell and Reed, the Council accepted this offer.

(b) *Stag party.* On motion of Drs. C. J. Clark and Garner, no charge is to be made for the Monday evening men's smoker, which, this year, will last all evening. Persons not registered in the hotel will pay the usual hotel charge of $3.00 for the dinner. The women will have their separate entertainment.

(c) *Banquet.*

1. *Entertainment.* On motion of Drs. Catlett and Elton Clarke, the Council approved the engagement of the Evansville Scottish Rite male choir for a twenty-minute program at the banquet on Wednesday evening.

2. *Dinner.* The Council rejected the offer of the hotel to provide a sirloin steak dinner at $2.50 extra charge per person, on motion of Drs. C. J. Clark and Garner.

(d) *Tipping.* Action on the suggestion of the hotel management that all tipping might be eliminated during the convention by adding 15 percent to all food and beverage charges and 5 percent on room charges for each guest was deferred for consideration at a later Council meeting. In the meantime Doctor Cockrum is to check with other organizations whose conventions have operated under this system. Doctor Cockrum explained that with a $16.00 per day room charge, $5.50 is designated for food and $10.50 per day for room. This would mean a 15 percent charge on $5.50, or 82½c per day, and a 5 percent charge on $10.50, or 52½c per day, or a total of $1.35 a day per person for all tips.

(e) *Type of scientific meetings.* Doctor Cockrum reported that it is the unanimous opinion of the Committee on Arrangements that each section should be represented with its own speaker on the general program. Extracurricular activities of sections, such as luncheons for and with their speakers, are to be encouraged. The scientific program then would consist of essentially general programs, thus providing sizable audiences for all speakers. The committee feels that an attempt should be made to avoid the small attendance which some of the section meetings have had in the past when nationally-known physicians have been invited to speak. On motion of Drs. C. J. Clark and Mitchell, the Council concurred in the suggestion of the Arrangements Committee that general meetings only be held, with each section having the privilege of choosing one speaker.

(f) *Proposal of the Indiana Academy of General Practice to supply speaker.* The executive secretary read a letter, addressed to Doctor Cockrum, from the secretary of the Indiana Academy of General Practice, in which the Academy expressed the desire to sponsor a nationally-known speaker for an evening meeting during the French Lick session. This proposal was rejected by the Council, on the motion of Drs. C. J. Clark and Combs. The Council directed that a letter be sent to the Academy secretary to the effect that no outside organization had ever been allowed to do this in the past and the Council feels that this should not be done.

(g) *Women's entertainment.* The women's entertainment program will be turned over to the members of the Vanderburgh County Auxiliary. They will appoint their own committee, and, at the suggestion of the Committee on Convention Arrangements, will ask someone from Orange county to serve on this committee.

(h) *Budget.* The request of the Convention Arrangements Committee for a budget of $5,450 was granted on motion of Drs. C. J. Clark and Mitchell.

3. *Scientific exhibit.* The executive secretary reported that the Executive Committee had decided to have scientific exhibits at the French Lick meeting. An effort will be made to procure these from Indiana rather than from distant points.

4. *General outline of program,* including the foregoing suggestions, follows:

Sunday September 24, 1950

Executive Committee dinner and meeting.

Monday, September 25, 1950

Morning— Registration
Instructional courses
Technical and scientific exhibits
Annual golf tournament
Annual trap and skeet shoot
Council meeting
Editorial Board meeting
Bowling tournament

Afternoon—Instructional courses
House of Delegates' meeting

Evening— Supper, smoker and stag party
Women's entertainment

Tuesday, September 26, 1950

Morning— Breakfast meetings of various groups
General scientific meeting

Noon— Class and fraternity get-togethers and luncheons
Veterans' luncheon

Afternoon—General scientific meeting
Section meetings for election of section officers

Evening— Dinner dance, with "name band"

Wednesday, September 27, 1950

Morning— Breakfast meetings of various groups
General scientific meeting
Final meeting of House of Delegates
Final Council meeting

Noon— Luncheon meetings

Afternoon—General scientific meeting
Section meetings for election of section officers

Evening— Annual banquet

5. *Banquet speaker.* Doctor Black asked for an opinion on what type of speaker should be secured for the banquet—scientific or entertainer. It was the consensus of the Council that the banquet program should consist of entertainment.

6. *Hotel rates.* French Lick Springs Hotel rates for the session will be as follows:

Single with bath—$14.00 per day.

Double with bath—$12.00 per day per person.

Double with lavatory and toilet—$10.00 per day per person.

Double with running water—$9.00 per day per person.

Parlors—$12.00 per day.

The breakdown on the meal rates for those persons registered in the hotel will be: $5.00 per day (breakfast $1.50, luncheon $1.50, and dinner $2.50); the remainder of the rate to be considered as room rent.

For those persons staying outside the hotel the meal rate will be as follows: breakfast $1.50, luncheon $2.00 and dinner $3.00; tickets to be purchased from the hotel cashier.

The check-out hours are 11:00 A.M. and 4.00 P.M.

Membership Problems

1. *Interpretation of Constitution concerning "senior members."* The question of when a physician is entitled to senior membership—in the year in which he becomes 75 years of age, or after he has passed his seventy-fifth birthday—was presented to the Council for clarification. On motion of Drs. May and Elton Clarke, the Council ruled that the Constitution be interpreted to mean that a physician is entitled to be classified as a "senior member" *the year after he has reached the age of 75.*

2. *Membership report.*

County Society	No. M.D.'s in* County	Members Dec. 31, 1949	Members Dec. 31, 1948	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
1st District									
Posey	15	14	13	1		1	3		
Vanderburgh	205	187	178	9	2	11	19	5	4
Warrick	14	9	11	—2		1	5		
*Spencer	12	10	9	1			1	1	
*Perry	12	12	11	1		1		1	
*Gibson	27	27	29	—2			2		
*Pike	10	10	9	1		2	1		
Total	295	269	260	9	2	16	31	7	4
2nd District									
*Knox	55	49	40	9	1	4	3	2	1
Daviess-Martin	31	26	24	2	3	2	2		
*Sullivan	24	20	19	1		1	7		
Greene	22	21	20	1	1				
Owen-Monroe	48	47	46	1		2	2	1	
Total	180	163	149	14	5	9	14	3	1
3rd District									
*Lawrence	33	30	28	2		1	5		
*Orange	14	14	15	—1			1		
Crawford	4	4	4						
*Washington	10	10	10				1		
Scott	7	4	4		1		2		
Clark	29	24	21	3	3		3	1	
*Floyd	38	35	34	1	1	2	2	2	1
*Harrison	11	11	11						
*Dubois	20	18	18		1		2		
Total	166	150	145	5	6	3	16	3	1
4th District									
*Bartholomew-Brown	36	30	30		1	1	3	4	3
Decatur	18	15	15		1		2	1	
Jackson	19	18	18			1	1		
*Jennings	10	8	9	—1	2		1		
Ripley	15	12	12		1	1	2		
Jefferson	21	19	22	—3	1	1	1		
*Switzerland	6	6	5	1		1	1		
*Dearborn-Ohio	18	16	18	—2	1				1
Total	143	124	129	—5	7	5	11	5	4
5th District									
Parke-Vermillion	28	24	27	—3	2		3		
Putnam	21	20	19	1			1	1	1
Vigo	133	121	121		2	5	8	1	5
Clay	14	12	13	—1			2		
Total	196	177	180	—3	4	5	14	2	6
6th District									
Hancock	20	18	20	—2	2		1		
*Henry	40	38	36	2	1	2	1		1
Wayne-Union	86	75	67	8	2	6	10	4	3
Rush	14	12	13	—1			1	1	
Fayette-Franklin	26	22	21	1			2		2
Shelby	29	21	25	—4	3		5	1	
Total	215	186	182	4	8	8	20	6	6
7th District									
*Hendricks	22	19	18	1	2	1	1		1
*Marion	967	855	845	10	60	55	80	18	21
*Morgan	24	20	22	—2	1		3		
*Johnson	22	19	19		2		1		1
Total	1035	913	904	9	65	56	85	18	23
8th District									
Madison	101	94	86	8	3	7	4	2	2
*Delaware-Blackford	113	103	104	—1	3	8	6	3	3
*Jay	24	21	20	1	2	1	1		
*Randolph	29	25	26	—1	3	2	1		
Total	267	243	236	7	11	18	12	5	5
9th District									
Benton	11	10	10		1	1			
*Fountain-Warren	18	17	18	—1	1		1		
*Tippecanoe	104	100	97	3	1	6	5		
*Montgomery	35	29	32	—3	4		4		
Clinton	30	28	29	—1		1	2	1	
Tipton	15	12	12				3		
Boone	27	22	20	2	2	1	3		
Hamilton	27	24	24				2	1	2
White	8	4	4				2	1	2
Total	275	246	246		9	9	22	3	4
10th District									
*Lake	321	296	295	1	9	17	24	3	4
*Porter	30	27	27		1	2	2	2	
*Jasper-Newton	23	20	21	—1		2	5	1	
Total	374	343	343		10	21	31	6	4
11th District									
Carroll	11	11	10	1					
Cass	45	36	35	1	2	2	5	1	2
Miami	23	19	21	—2	2				2
*Wabash	27	23	23		2	2	3		
Huntington	25	23	24	—1	1				1
*Howard	48	43	38	5		2	5	1	2
Grant	64	53	54	—1	6		5		1
Total	243	208	205	3	13	6	18	2	8

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

County Society	No. M.D.'s in* County	Members Dec. 31, 1949	Members Dec. 31, 1948	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
12th District									
LaGrange	7	7	5	2					
Steuben	17	10	12	—2	4	1	2	1	
*Noble	27	27	27			1	2		
DeKalb	23	21	21		2	1	1		
Whitley	16	12	12		1		1		2
Allen	217	198	199	—1	4	10	11	4	9
Wells	33	29	22	7	1	8	4		
*Adams	19	19	17	2		4	1		
Total	359	323	315	8	12	25	22	5	11
13th District									
LaPorte	73	66	62	4	3	6	4	3	
*St. Joseph	211	191	183	8	9	12	10	2	3
*Elkhart	89	85	81	4		5	8	1	
Starke	6	6	6						
*Pulaski	10	9	8	1	1		1		
Fulton	15	13	12	1			1	1	
*Marshall	29	26	25	1	2	4	1		1
Kosciusko	22	17	18	—1	3	2	4		
Total	455	413	395	18	18	29	29	7	4
SUMMARY BY DISTRICTS									
1st District	295	269	260	9	2	16	31	7	4
2nd District	180	163	149	14	5	9	14	3	1
3rd District	166	150	145	5	6	3	16	3	1
4th District	143	124	129	—5	7	5	11	5	4
5th District	196	177	180	—3	4	5	14	2	6
6th District	215	186	182	4	8	8	20	6	6
7th District	1035	913	904	9	65	56	85	18	23
8th District	267	243	236	7	11	18	12	5	5
9th District	275	246	246		10	9	22	3	4
10th District	374	343	343		11	21	31	5	4
11th District	243	203	205	3	13	6	18	2	8
12th District	359	323	315	8	12	25	22	5	11
13th District	455	413	395	18	18	29	29	7	4
Total	4203	3758	3689	69	170	210	325	71	81

* Physicians are listed in the counties in which they hold membership; not in the counties in which they reside.

36 physicians received membership gratis in 1949 because of military service.

189 physicians were honorary members in 1949.

Legislative Matters

Dr. Elton Clarke discussed the Federal Aid to Medical Education bills, S. 1453 and H. R. 5940, and the National School Health Service Act of 1949, S. 1411. Doctor Clarke's motion "that this Council go on record as opposing H. R. 5940 and the House bill corresponding to S. 1411 and make our action known to President Truman, our senators and especially our representatives in Congress, and also to the A.M.A. and our Indiana delegates to the A.M.A." was seconded by Doctor May and passed.

New Business

1. *Indiana Inter-Professional Health Council.* On motion of Drs. Mitchell and Howard, Dr. E. H. Clauser and Dr. William C. Reed were reappointed to serve as members of the Committee on Indiana Inter-Professional Health Council for 1950.

2. *Alternate councilors.* On motion of Drs. C. J. Clark and Mitchell, alternate councilors are to be invited to all meetings of the Council.

3. *Postgraduate education.* Doctor Klepinger, chairman of the Committee on Medical Education and Hospitals, asked the Council for suggestions and criticisms on the proposed postgraduate education program. "The committee feels that probably it should work up a program of a dozen subjects with a team of teachers and practicing physicians for each subject, to give that subject and offer it to whoever wants it in the state, whenever they want it, if that can be arranged. The letters which were sent to you were to get your reaction as to the subject matter and whether the men in your district would be interested. We would like to have your suggestions and criticisms. We want to know if we are on the right track. The councilors could act as advisors in those districts where meetings are desired and suggest the number of meetings." This subject was discussed by Drs. Combs, Mitchell and C. J. Clark.

4. *Committee on Mental Health.* Doctor Hahn, chairman, presented the following report which, previous to the Council meeting, had been sent to Doctor Black:

At its meeting of November 7, 1949, your Committee on Mental Health adopted some resolutions embodying a program of assistance to the constituent county societies in establishing and maintaining a healthy relationship with county chapters of the Indiana Mental Hygiene Society.

The Committee directed me to request your approval and that of the Indiana State Medical Association Council before putting this program in effect.

Perhaps I should explain that the Indiana Mental Hygiene Society has enjoyed a remarkable growth and that its aggressive program of public education is in charge of influential and capable officers. Already some five county chapters have been organized and others will come into being within the year. Each of these chapters will be stimulated by the state organization to arrange public forums on psychiatric matters, to distribute literature, and to assist in the establishment of child guidance and other psychiatric services.

It was the thought of your Committee on Mental Health that these activities of the various mental hygiene chapters should be carried forward with the encouragement and the guidance of the county medical societies. If this condition should not be maintained there might be some tendency for certain phases of psychiatry to escape from its moor-

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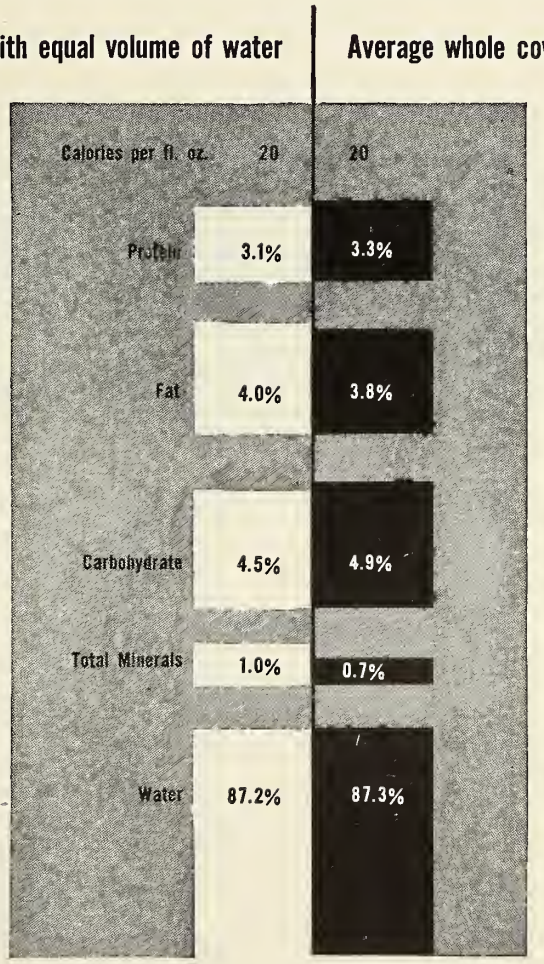

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ings in scientific medicine, with results detrimental to public welfare.

Your Committee on Mental Health, therefore, wishes permission to act as a liaison agency between the Indiana State Medical Association and the Indiana Mental Hygiene Society and permission to encourage such liaison at the county level between medical societies and mental hygiene chapters. Your Committee would also expect to maintain liaison with the Indiana Neuropsychiatric Association and the Indiana Council for Mental Health, reporting to the House of Delegates on the accomplishments and trends of those organizations as they bear upon mental health.

Specifically, if the Committee's program is approved, the following immediate steps would be taken:

1. By letter, each county society would again be alerted to the activities of the Indiana Mental Hygiene Society.
2. Each county society would be urged to designate some individual member or committee to act as liaison agent between it and the local chapter of the Indiana Mental Hygiene Society, with the dual purpose of encouraging the mental hygiene movement and of lending it *medical guidance.*
3. Each county society and its auxiliary would be offered the services of your Committee on Mental Health for providing speakers qualified to explain the common aims of the Mental Hygiene Society and of *medical* psychiatry.
4. The Indiana Mental Hygiene Society would be requested to provide reports on its activities of public education, chapter organization, and policies, to the end that the county medical societies can be alerted to their responsibilities and opportunities in furthering the cause of a sound psychiatric educational program.

The Council approved Doctor Hahn's report on Dr. C. J. Clark's motion "that the Committee on Mental Health be instructed to use whatever means it can to aid and inform the county medical societies concerning the guidance of these district chapters of the Indiana Mental Hygiene Society," which was seconded by Doctor Howard. Doctor Clark added, "I certainly think the committee should use whatever means it can to keep the thing under medical guidance. The county societies should be on their toes and keep it under control."

Doctor Portteus asked for the same sort of support for the Indiana Council for Mental Health, and it was taken by consent that this be incorporated in the above motion.

5. *Committee on Tuberculosis.* Doctor Crimm, chairman, presented the following report, which was approved by the Council on motion of Drs. C. J. Clark and Combs:

These recommendations are respectfully submitted to the Council of the Indiana State Medical Association, for approval, rejection or revision.

(1) This Committee believes that all organizations which promote any phase of tuberculosis work should express their emphatic opposition to any form of socialized medicine or compulsory health insurance. We understand the Indiana Hospital Association has made such a resolution and we think other organizations, such as the Indiana Tuberculosis Association, the State Board of Health, and the Indiana Chapter of the American Red Cross, should follow suit. It is also recommended that these state organizations encourage their national organizations to do likewise. (We would appreciate a copy of their resolutions.)

(2) The Committee thinks more study is advised concerning the number of available beds for the care of patients suffering from active tuberculosis, before any request is made for additional beds. We believe no new sanatoria should be built, but if needed, more beds can be added to present facilities. We commend the Indiana Council on Tuberculosis for beginning this investigation. We urge general hospitals to admit tuberculous patients (where isolation and bed rest is needed) until they can be transferred to specialized hospitals or sanatoria for treatment.

(3) We advise that tuberculosis and health organizations request the State Legislature to make it mandatory that all food handlers, in grocery stores, restaurants, hotels, and drug stores, and dishwashers and bartenders, have a chest x-ray annually in order to work in such establishments. Furthermore, we advise that this routine x-ray be made a part of the drug store, hotel, tavern and restaurant's requirements for license—cost of the x-ray to be paid by either employee or employer, or both, and the state medical society to fix the x-ray charge for the entire state, both on miniature and large 14 x 17 films.

(4) We request the State Legislature to pass a law that county commissioners are to allot sufficient funds to hospitalize cases of tuberculosis in any sanatorium in the state, in keeping with the policy of the state of Indiana, viz., the patient or relative of patient is obligated to pay part of the cost if financially able. The county commissioners should be required to hospitalize any active case if requested to do so, especially the indigent.

(5) The State Board of Health should be commended for its effort to quarantine recalcitrant cases of active tuberculosis in sanatoria and all other active cases who fail to obey precautions advocated by their physicians. We urge them to instruct all County and City Health Officers to enforce the law vigorously.

The Tuberculosis Committee, appointed by President Black, met in Indianapolis on November 9, 1949.

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6. *Nominations for Editorial Board.*

(a) The resignation of Dr. Wemple Dodds was read and accepted on motion of Drs. Mitchell and Reed. On motion of Drs. Olson and Howard, Dr. David A. Bickel, of South Bend, was elected to fill Doctor Dodd's unexpired term, ending December 31, 1952.

(b) Dr. C. J. Clark nominated Dr. Clyde G. Culbertson, Indianapolis (research). Additional nominations are to be made at the next Council meeting.

7. *Spring meeting of the Council.* It was taken by consent that the next meeting of the Council should be held on Sunday, April 16, 1950.

Elections for 1950

1. *Executive Committee members.* Dr. C. J. Clark nominated Dr. W. L. Portteus to succeed himself. Doctor Combs nominated Dr. C. J. Clark. On motion of Drs. Mitchell and Reed, the nominations were closed and the secretary cast the unanimous ballot of the Council for Drs. Portteus and C. J.Clark.

2. *Chairman of the Council.* On motion of Doctor Clauser, seconded by several, Dr. W. U. Kennedy was re-elected chairman of the Council for 1950.

There being no further business, the meeting was adjourned.

EXECUTIVE COMMITTEE

January 14, 1950

Roll call showed the following present: W. L. Portteus, M.D., acting chairman; C. S. Black, M.D.; Alfred Ellison, M.D.; W. U. Kennedy M.D.; A. F. Weyerbacher, M.D.

Albert Stump, attorney; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Guests: E. R. Clarke, M.D., Kokomo, chairman of the Council Pension Study Committee; Charles W. Vandenbark and Eldon H. Nyhart of The Howard E. Nyhart Company, Inc., Indianapolis; and C. C. Fridlin, Kokomo, representative of the Jefferson National Life Insurance Company.

Membership Report

Number of members December 31, 1949	*3,758
Number of members December 31, 1948	3,689
Gain over 1948	69

* Includes 36 in military service (gratis) 189 honorary members.

Number of members who paid 1949 A.M.A. assessment	2,607
Number of members January 14, 1950	1,051
Number of members January 15, 1949	1,506
Loss over this time last year	455

Treasurer's Office

The auditor's report for 1949 was presented and discussed by the treasurer.

1950 Annual Session, French Lick, September 25, 26, and 27, 1950

The executive secretary reported on the meeting held with the Committee on Convention Arrangements on January 12, 1950, at French Lick.

Preliminary convention program was read and approved on motion of Drs. Weyerbacher and Ellison.

Results of a questionnaire sent out by the Oklahome State Medical Association concerning the wishes of doctors regarding arrangements for annual meetings was read.

Statements of receipts and expenditures for December for the association and THE JOURNAL were approved.

Indiana A.M.A. Campaign Coordinating Committee

The field secretary reported on the activities of the Indiana A.M.A. Campaign Coordinating Committee.

On motion of Drs. Kennedy and Weyerbacher the chairman of the Committee on Public Relations was authorized to attend the A.M.A. Conference of the National Education Campaign in Chicago February 12.

Venereal Disease

On motion of Drs. Black and Weyerbacher the suggested program of the Committee on Venereal Disease was approved.

Organization Matters

"One Hundred Years of Indiana Medicine." On motion of Drs. Ellison and Kennedy, the unsold copies of "One Hundred Years of Indiana Medicine" are to be offered for sale at $2.50 per copy. Copies on hand after the 1950 annual convention are to be sent to the libraries in the state.

On motion of Drs. Ellison and Black the committee rescinded its previous action authorizing Dr. R. A. Solomon to attend the United States Pharmacopoeial Convention in Washington, D.C., May 9 and 10, 1950, as a delegate from the association, inasmuch as Dr. Solomon has been selected as a delegate by the Indiana University School of Medicine. Dr. Frank B. Fisk will serve as the association's delegate to this convention and will pay his own expenses.

Waiver of payment of state dues. On motion of Drs. Weyerbacher and Kennedy, the requests of secretaries of three county medical societies that members who are incapacitated on account of illness be excused from paying state dues were referred to the Council.

Life insurance examination fees survey. The sending of a questionnaire on life insurance examination fees, voted by the Council on August 28, was tabled, on motion of Drs. Ellison and Weyerbacher.

Request for contribution from Associated Postgraduate Committee. The committee, by consent, tabled a request from the Associated Postgraduate Committee for a $25.00 contribution, pending receipt of more information about it.

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Standards of approval for disability insurance. A letter from Richard A. Calkins, president of the Disability Income Insurance Company of Indianapolis, suggesting the setting of standards of approval for disability insurance, was referred to the Council.

The Journal

Request of University Microfilms, of Ann Arbor, Michigan, for permission to reproduce material in THE JOURNAL was referred to the association's attorney for study.

Printing Contract for 1950. On motion of Drs. Black and Ellison, THE JOURNAL is to accept the new contract proposal of C. E. Pauley and Company for 1950, at a reduction of approximately $200.00 on every 106-page issue, and a saving of approximately $75.00 per issue by substituting a different type of paper stock.

COMMITTEE ON PUBLICITY

January 6, 1950

Present: Marlow W. Manion, M.D., chairman; Homer G. Hamer, M.D.; James O. Ritchey, M.D.; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary; and James A. Waggener, field secretary.

Letter from the A.M.A. regarding the shipping charges for an exhibit loaned the Lawrence Central High School was read. The school returned the exhibit collect and the A.M.A. desired the committee's attitude on their writing the school for payment. The committee agreed, by consent, that the charges should be paid by the committee.

The secretary reported that two television programs had been used, the first on Friday, December 30, 1949, the second on Wednesday, January 4, 1950. The third show is scheduled for Tuesday, January 17, 1950.

The committee agreed that further effort should be made to secure additional material for use on television programs.

LOCAL SOCIETY REPORTS

LOCAL SOCIETY OFFICERS

BARTHOLOMEW-BROWN COUNTY MEDICAL SOCIETY
President, E. W. Williams, Columbus,
Vice-President, T. D. Carpenter, Columbus,
Secretary-Treasurer, D. L. Adler, Columbus.

BENTON COUNTY MEDICAL SOCIETY
President, Vern Turley, Fowler,
Secretary-Treasurer, Charles G. Smith, Otterbein.

CLARK COUNTY MEDICAL SOCIETY
President, Nathaniel C. Isler, Jeffersonville,
Vice-President, Herman A. Mercer, Jeffersonville,
Secretary-Treasurer, Donald G. Sturgis, Sellersburg.

CLAY COUNTY MEDICAL SOCIETY
President, John C. Shattuck, Brazil,
Vice-President, Jack Glosson, Clay City,
Secretary-Treasurer, Robert K. Webster, Brazil.

DECATUR COUNTY MEDICAL SOCIETY
President, Russell M. Blemker, Greensburg,
Vice-President, E. A. Porter, Westport,
Secretary-Treasurer, James C. Miller, Greensburg.

DELAWARE-BLACKFORD COUNTIES MEDICAL SOCIETY
President, K. N. Venis, Muncie,
President-Elect, L. G. Montgomery, Muncie,
Secretary, J. H. Clevenger, Muncie,
Treasurer, W. J. Molloy, Muncie.

FLOYD COUNTY MEDICAL SOCIETY
President, Phillip Cohn, New Albany,
Secretary-Treasurer, Daniel H. Cannon, New Albany.

FULTON COUNTY MEDICAL SOCIETY
President, Dean K. Stinson, Rochester,
Vice-President, V. C. Miller, Akron,
Secretary, J. C. Glackman, Rochester.

GIBSON COUNTY MEDICAL SOCIETY
President, Virgil C. McCarty, Princeton,
Vice-President, Austin Marchand, Haubstadt,
Secretary-Treasurer, James F. Peck, Princeton.

GRANT COUNTY MEDICAL SOCIETY
President, P. J. Fisher, Marion,
Vice-President, A. Ward Bloom, Marion,
Secretary-Treasurer, Russell W. Lavengood, Marion.

HAMILTON COUNTY MEDICAL SOCIETY
President, J. C. Ambrose, Noblesville,
Vice-President, Haldon Kraft, Noblesville,
Secretary-Treasurer, Sam W. Campbell, Carmel.

HENRY COUNTY MEDICAL SOCIETY
President, J. G. Bledsoe, New Castle,
Vice-President, Victor Albright, New Castle,
Secretary-Treasurer, C. E. Thorne, New Castle.

HUNTINGTON COUNTY MEDICAL SOCIETY
President, J. B. Bennett, Warren,
Vice-President, Thomas James, Jr., Huntington,
Secretary-Treasurer, William A. Clunie, Huntington.

JACKSON COUNTY MEDICAL SOCIETY
President, C. E. Gillespie, Seymour,
Vice-President, J. M. Black, Seymour,
Secretary-Treasurer, G. H. Kamman, Seymour.

JENNINGS COUNTY MEDICAL SOCIETY
President, W. H. Stemm, North Vernon,
Vice-President, Benet W. Thayer, North Vernon,
Secretary-Treasurer, John H. Green, North Vernon.

JOHNSON COUNTY MEDICAL SOCIETY
President, C. F. Deppe, Franklin.
President-elect, Wm. D. Province, Franklin.
Secretary-Treasurer, George M. Murphy, Franklin.

MARSHALL COUNTY MEDICAL SOCIETY
President, R. C. Stephens, Plymouth,
Vice-President, Donald Reed, Culver,
Secretary-Treasurer, L. W. Vore, Plymouth.

MIAMI COUNTY MEDICAL SOCIETY
President, E. E. Shrock, Amboy.
Vice-President, Owen Johnson, Peru.
Secretary-Treasurer, C. R. Herd, Peru.

MONTGOMERY COUNTY MEDICAL SOCIETY
President, E. E. Richards, Russellville.
Vice-President, F. Dale Johnson, Waynetown.
Secretary-Treasurer, Stephen J. Alexander, Crawfordsville.

MORGAN COUNTY MEDICAL SOCIETY
President, Bernard Karpel, Mooresville,
Secretary-Treasurer, R. M. Seibel, Morgantown.

ORANGE COUNTY MEDICAL SOCIETY
President, W. E. Schoolfield, Orleans,
Vice-President, N. E. Keseric, French Lick,
Secretary-Treasurer, Keith Hammond, Paoli.

PARKE-VERMILLION COUNTIES MEDICAL SOCIETY
President, Joseph R. Bloomer, Rockville.
Secretary-Treasurer, W. D. Britton, Montezuma

An Observation on the Accuracy of Digitalis Doses

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1. *Withering, W.:* An account of the Foxglove, London, 1785.
2. *Rimmerman, A. B.:* Digilanid and the Therapy of Congestive Heart Disease, Am. J. M. Sc. *209:* 33-41 (Jan.) 1945.

Literature giving further details about Digilanid and Physician's Trial Supply are available on request.

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PORTER COUNTY MEDICAL SOCIETY
President, J. R. Frank, Valparaiso,
Vice-President, J. W. Dale, Chesterton,
Secretary-Treasurer, Ralph C. Eades, Valparaiso.

PUTNAM COUNTY MEDICAL SOCIETY
President, Cleon M. Schauwecker, Greencastle,
Secretary-Treasurer, Anne S. Nichols, Greencastle.

RIPLEY COUNTY MEDICAL SOCIETY
President, L. H. Hopkins, Versailles,
Secretary-Treasurer, L. L. Lippoldt, Batesville.

RUSH COUNTY MEDICAL SOCIETY
President, Kenneth F. C. Corpe, Rushville,
Vice-President, Frank H. Green, Rushville,
Secretary-Treasurer, Davis W. Ellis, Rushville.

TIPPECANOE COUNTY MEDICAL SOCIETY
President, George W. Herrold, Lafayette,
Vice-President, R. R. Calvert, Lafayette,
Secretary, J. C. Burkle, Lafayette,
Treasurer, William M. Sholty, Lafayette.

VIGO COUNTY MEDICAL SOCIETY
President, Edward C. Voges, Terre Haute,
Vice-President, R. E. Edmondson, Terre Haute,
Secretary-Treasurer, A. M. Mitchell, Terre Haute.

Adams County Medical Society members held a dinner meeting on January 10 at Adams County Hospital, Decatur, and plans were discussed for making twenty-four-hour medical service available. Eighteen members were present.

Benton County Medical Society members met at Fowler, on January 24 and witnessed a moving picture on the subject of gastroscopy.

Clay County Medical Society members held a meeting on January 17 at the Elks Home in Brazil. Six members were present.

Clinton County Medical Society members met at the Clinton County Hospital on January 3 with sixteen members present. A business meeting was held.

Fayette-Franklin Counties Medical Society members met at Connersville January 10. Fourteen members were present.

Floyd County Medical Society members met at New Albany, on January 13, and voted to approve a new hospital of seventy-five or more beds, and to continue the physicians' exchange at New Albany Apothecary shop, as a means of locating a doctor at any time.

Greene County Medical Society members met at Freeman Greene County Hospital, Linton, January 12. Thirteen members were present.

Hamilton County Medical Society members met at Noblesville on January 10 and heard Dr. F. W. Teague give a paper on common shoulder injuries. Seventeen members were present.

Hendricks County Medical Society members met at Avon on January 12. Dr. Herbert Call, of Indianapolis, led the discussion in a pediatric panel. A vote was taken to increase medical society dues. Resolution was passed against socialized medicine to be sent to congressmen and local organizations. Eight members were present.

Howard County Medical Society members met January 6 at Kokomo. Twenty-six members were present.

Knox County Medical Society members met at Vincennes on January 17, and heard Dr. George J. Garceau, of Indianapolis, speak on Colle's and Pott's Fractures. Twenty-four members were present.

Lawrence County Medical Society members held a dinner meeting January 4 at the Greystone Hotel in Bedford with wives and other guests. Speaker was Dr. James L. Doenges, of Anderson.

Madison County Medical Society members met at the Anderson Country Club on January 16 for a dinner-meeting. Dr. Robert M. Vandivier, of Indianapolis, read a paper on "Non-Specific Diseases of the Chest." Forty-four members were present.

Marshall County Medical Society members met at Plymouth, on February 1. Dr. John Thompson of South Bend discussed the problem of squint. Sixteen members were present.

Miami County Medical Society members met at Civic Center, in Peru, on January 27, and heard a representative of the F.B.I. of Indianapolis speak on the work of that organization. It was a dinner meeting at which members of the Women's Auxiliary were guests.

Montgomery County Medical Society members met at Culver Hospital, in Crawfordsville, January 19. Dr. Sidney A. Kaufmann, of Indianapolis, spoke on "Therapy in Pediatrics." Twenty-five members were present.

Orange County Society members met at West Baden Springs Hotel, December 6, and heard Dr. H. Lester Reed, of Louisville, speak on recognition of spinal cord lesions. Twelve members attended.

Another meeting was held at Paoli in the residence of Dr. John K. Spears, for election of officers on December 20.

Owen-Monroe Counties Medical Society members met at the Bloomington Country Club, January 26. Dr. Bert Ellis of Indianapolis gave a paper on congenital cysts of the head and neck. Twenty-five members were present.

Parke-Vermillion County Medical Society members met at Vermillion County Hospital, at Clinton, on January 18, to hear Dr. H. B. Perkle talk on childhood tuberculosis. Fourteen members were present.

Putnam County Medical Society members met at Greencastle on December 9 for election of officers. Sixteen members attended.

Randolph County Medical Society members met at Randolph County Hospital in Winchester on January 9. Fifteen members were present for discussion of the County Welfare Department.

Ripley County Medical Society members met at Batesville, on January 25, for election of officers. Nine members were present.

Tippecanoe County Medical Society members met in Lafayette on January 10, with sixty members present. C. G. Weigand of the Lilly Research Laboratories gave a talk on information on vitamin deficiencies, illustrated by Kodachromes. A discussion followed.

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Vanderburgh County Medical Society members met January 10 at Evansville. Guest speaker was Dr. Amos Christie, Professor of Pediatrics at the Vanderbilt University School of Medicine, who spoke on histoplasmosis. One hundred and three members attended.

Wabash County Medical Society members met at Wabash on January 11, and heard Dr. Dan Urschel of Mentone talk on the management of cardiac decompensation. Also there was a film from Ciba Pharmaceutical Company on saddle block anesthesia in obstetrics. Twenty members attended.

Whitley County Medical Society members met at Columbia City, on January 10. Dr. Richard Terrill of Fort Wayne spoke on types of retinopathy. Eight members were present.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. Truman Caylor, Bluffton.

President-elect—Mrs. D. E. Lybrook, Galveston.

Corresponding Secretary—Mrs. Harry Harvey, Fort Wayne.

Recording Secretary—Mrs. Bert Ellis, Indianapolis.

Treasurer—Mrs. Wendell Kelley, Anderson.

Press and Publicity—Mrs. Clande S. Black, Warren.

The House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association will meet at the Hotel Elkhart, in Elkhart, April 27 and 28. All delegates should make their reservations by April 1.

Registration begins at 1:30 P.M., April 27, and the Board Meeting will be held at 3:00 P.M. on that date. That evening there will be a social hour at 6:00 and a dinner at 7:00 P.M.

On April 28 there will be a memorial breakfast at 9:00 A.M.; the House of Delegates will meet at 10:00 A.M.; and there will be a luncheon at 1:00 P.M.

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Dearborn-Ohio Counties
Fayette-Franklin Counties
Jasper-Newton Counties
Orange County
Pulaski County
Putnam County
Tipton County
Washington County
Whitley County

INDIANA STATE BOARD OF HEALTH
Division of Communicable Disease Control

MONTHLY REPORT—NOVEMBER, 1949

Diseases	Nov. 1949	Oct. 1949	Sept. 1949	Nov. 1948	Nov. 1947
Chickenpox	140	72	8	368	311
Diphtheria	38	34	55	38	73
Dysentery,					
Amoebic	3	1	0	11	0
Encephalitis	2	3	5	4	2
Food poisoning,					
Salmonella	1	1	0	0	0
Influenza	20	18	4	105	53
Measles	92	87	24	93	51
Meningitis,					
Meningococcal	2	5	1	1	3
Unclassified	5	4	1	3	8
Mumps	72	42	9	72	75
Pneumonia	26	21	19	65	42
Poliomyelitis					
Paralytic	22	45	78	14	15
Non-paralytic	11	22	30	3	4
Unspecified	32	125	130	2	0
Rabies in animals	36	59	17	54	29
Rubella	15	11	0	11	6
Scarlet fever	118	77	32	136	252
Septic Sore Throat	1	5	0	3	8
Tetanus	1	2	2	2	1
Tinea capitis	7	28	5	6	51
Tuberculosis,					
Pulmonary	168	219	130	137	223
Other forms	18	14	18	6	23
Typhoid fever	3	3	3	3	7
Whooping cough	88	88	73	68	274

MONTHLY REPORT—DECEMBER 1949

Disease	Dec. 1949	Nov. 1949	Oct. 1949	Dec. 1948	Dec. 1947
Brucellosis	2	0	5	0	10
Chickenpox	236	140	72	313	464
Diphtheria	33	38	34	45	49
Encephalitis	3	2	0	1	2
Erysipelas	3	0	1	0	2
Food poisoning,					
shigella	2	0	0	0	0
Impetigo	5	0	3	1	2
Influenza	26	20	18	15	33
Malaria	1	0	0	0	2
Measles	111	92	87	118	217
Meningitis,					
Unclassified	4	5	4	2	9
Influenzal	4	0	0	0	2
Meningococcal	8	2	5	4	2
Pneumococcal	1	0	0	0	0
Mumps	147	72	42	112	106
Paratyphoid fever	1	0	1	0	0
Pneumonia	45	26	21	53	48
Poliomyelitis,					
Paralytic	6	22	45	6	11
Nonparalytic	3	11	22	0	3
Unspecified	20	32	125	3	3
Rabies, animal	39	36	59	65	29
Rubella	75	15	11	4	5
Scarlet fever	200	118	77	217	227
Tinea capitis	3	7	28	10	20
Trachoma	2	0	0	0	0
Tuberculosis,					
pulmonary	111	168	219	158	146
Other forms	8	18	14	10	13
Tularemia	7	0	0	23	9
Typhoid fever	3	3	3	1	3
Vincent's angina	4	0	7	1	1
Whooping cough	87	88	88	46	180

Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

BOOKS RECEIVED

ELECTROCARDIOGRAPHY—Fundamentals and Clinical Application. By Louis Wolf, M.D., visiting physician, consultant in cardiology, and chief of the Electrocardiographic Laboratory, Beth Israel Hospital: associate in medicine, Harvard Medical School. 187 pages with 110 figures. Price $4.50. W. B. Saunders Company, Philadelphia, 1950.

QUESTIONS Medical State Board and ANSWERS. By R. Max Goepp, M.D., formerly professor of clinical medicine, Graduate School of the University of Pennsylvania, and professor of medicine, Woman's Medical College of Pennsylvania; and Harrison F. Flippin, M.D., associate professor of medicine at the Graduate School of the University of Pennsylvania. 8th edition. 663 pages. Price $7.00. W. B. Saunders Company, Philadelphia, 1950.

CLINICAL PATHOLOGY—Application and Interpretation. By Benjamin B. Wells, M.D., professor of medicine, University of Arkansas School of Medicine. 397 pages with 32 figures. Price $6.00. W. B. Saunders Company, Philadelphia, 1950.

PRACTICAL AND THEORETICAL ASPECTS OF PSYCHOANALYSIS. By Lawrence S. Kubie, M.D., clinical professor of psychiatry and mental hygiene, Yale University School of Medicine; faculty, New York Psychoanalytic Institute. 252 pages. Price $4.00. International Universities Press, New York City, 1950.

BODY AND MATURE BEHAVIOUR. A study of anxiety, sex, gravitation and learning. By M. Feldenkrais, London. 167 pages. Price $3.75. International Universities Press, New York City, 1950.

BOOKS REVIEWED

NORMAL VALUES IN CLINICAL MEDICINE. By F. William Sunderman, M.D., professor of Experimental Medicine and Clinical Pathology, University Texas Postgraduate School of Medicine; and Frederick Boerner, V.M.D., late associate professor of Clinical Bacteriology, Graduate School of Medicine, University of Pennsylvania. 845 pages with 237 figures and 413 tables. Price $14.00. W. B. Saunders Company, Philadelphia, 1949.

This magnificent and encyclopedic book has long been a crying need of everyone who is interested in modern scientific medicine. Presented in an ideal form by the authors, it should find its place in every doctor's office, and particularly in the record rooms and libraries of hospitals, medical schools and other medical educational institutions. Clinical pathologists in particular should find this a particularly useful and satisfying addition to their reference material.

L.G.M.

PSYCHOANALYTIC STUDY OF THE CHILD. Volume III/IV. Editorial Board: Phillis Greenacre, M.D., Heinz Hartmann, M.D., Edith B. Jackson, M.D., Ernst Kris, Ph.D., Lawrence S. Kubie, M.D., Bertram D. Lewin, M.D., Marian C. Putnam, M.D., Rudolph M. Loewenstein, M.D., Anna Freud, Willie Hoffer, M.D., and Edward Glover, M.D. 493 pages. Cloth. Price $10.00. International Universities Press, Inc., New York, 1949.

The twenty-one papers in this volume are well chosen and deal with child development, problems of psychoanalytic theory and clinical problems. The dynamically trained psychiatrist will benefit most from the papers in this volume. All who do clinical psychiatric work with children will find this volume stimulating and helpful. The pediatrician, with psychiatric orientation, will find many of the clinical articles of interest but will find little that will be of practical value in the pursuit of his practice.

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A PHYSICIAN'S ROLE IN THE FIGHT AGAINST CANCER*

LEONARD A. SCHEELE, M.D.

WASHINGTON, D.C.

The Author:

Doctor Scheele received an A.B. degree from the University of Michigan in 1933 and an M.D. cum laude from Wayne University in 1934. Following his internship in the U. S. Marine Hospital at Chicago, he was commissioned in the regular corps of the U. S. Public Health Service. After a two-year fellowship in cancer epidemiology at Memorial Hospital, New York City, he conducted cancer control activities in the National Cancer Institute. During the war he was detailed from 1943 to 1946 to the United States Army, where he served in the Mediterranean Theater of Operations and on the staff of General Eisenhower as chief of preventive medicine in the Public Health Branch, SHAEF. He was appointed Director of the National Cancer Institute in 1947 and became Surgeon General of the U. S. Public Health Service in 1948.

FOR several years, before taking my present job, I was a member of the staff of the National Cancer Institute, which is part of the Public Health Service. My experience in the Institute reinforced a conviction about cancer control which I already had. I am convinced that the practicing physicians, and more especially those in general practice, can do more than all other agencies and individuals combined to cut the cancer death rate sharply at the present time. This they can do by finding more cancer in its early stages.

In speaking so bluntly I hope that I do not seem unaware or unappreciative of the load which every physician already carries. In one campaign after another, governmental and voluntary agencies ask of him assistance and more assistance, until it seems that he staggers under a mountain of special appeals. I should like to help you dissociate cancer from this aura of special appeals, by relating it to the broader concept of total health. When the physician adds a constant vigilance for cancer to his other duties, he becomes a part not only of the specific lifesaving enterprise which the general public calls the "cancer drive," but he joins that deeper drive toward integration of the specialties in the study and treatment of disease. Integration is, indeed, the most promising trend in American medicine today.

The day is approaching, if indeed it is not already here, when the several phases of health must be dealt with as inseparable, and the different

* Presented at the centennial session of the Indiana State Medical Association, at Indianapolis, September 27, 1949.

skills and services that have been brought to such a high degree of specialized efficiency must become an integrated whole. The general physician is in a strategic position to stimulate consideration of the patient as a "whole man," so that he may obtain the benefits of all the special knowledge he needs. It would be a gross exaggeration to say that integration of the various scientific disciplines in the interests of "total health" has been accomplished as extensively as we would like to see. But as a principle, it is intensely alive everywhere, showing itself in all sorts of proposals, large or small.

The teamwork between private medicine and public health agencies in the United States illustrates one phase of the process of integration. We have learned to take for granted the cooperation between private practitioners and the health agencies. It follows largely a pattern set during the last half century, when one disease after another fell within the expanding reach of bacteriology, immunology and chemotherapy. During decades of magnificent progress physicians have been active in campaigns for safe water and milk, insect control, and immunization against communicable diseases. Their influence supported and built up local, state and federal public health agencies. A pattern was established which is still highly effective in dealing with communicable disease. As one recent example, a nation-wide campaign against tuberculosis, added to more adequate case-finding by individual physicians, has reduced the national death rate from tuberculosis by approximately 25 percent within five years. Public and voluntary agencies and the medical profession worked together smoothly to achieve this goal.

This is the pattern of the past. A still higher degree of voluntary integration will be necessary if we are to conquer cancer. Cancer cannot be overcome by the same methods we have used in dealing with communicable disease. Cancer brings us up sharply, face to face with the necessity for working out a new and wider concept of health services than we have so far achieved. I am not speaking of laws and formal programs; I am speaking of a state of mind—an attitude. With our present knowledge the death toll from this disease can be sharply reduced, but only if we relate this problem to the concept of total health for all the people. In all its phases, whether basic research into etiology, studies in epidemiology, the development of therapy, or intensified emphasis upon early case-finding and diagnosis, the fight against this disease calls for a united front.

This has become increasingly true as the years go by. The outstanding contributions to our knowledge of cancer in former years were made in pathology, biophysics and surgery, working as somewhat isolated fields. Now that a groundwork has been laid, these disciplines are drawn upon by others so that cancer research functions best when there can be close cooperation between workers in the basic sciences and in clinical medicine. A clinical center such as the new Goldblatt Memorial wing at Billings Hospital, now rising on the campus of the University of Chicago, illustrates this powerful trend. A still broader illustration will be the new Clinical Center of the National Institutes of Health of the Public Health Service in Bethesda, Maryland. Here not only the various scientific disciplines, but clinical medicine in its many phases, will be represented under one roof.

At the National Cancer Institute, which is one of the National Institutes of Health, the problems of cancer research and control are being simultaneously attacked, in close cooperation with the American Cancer Society, the Committee on Growth of the National Research Council, and other national professional organizations. The Public Health Service makes grants both for control and research, including assistance to a number of interesting projects at your own state university and Notre Dame University. I should like to mention the work of Dr. H. J. Muller, who is studying the production of cell mutations by ultraviolet light, and of Dr. Edward W. Shrigley, who is investigating the effect of viruses upon chick embryo metabolism, through the use of radioactive isotopes. The work of Dr. Tracy M. Sonneborn in the field of cytoplasmic inheritance may have very interesting consequences in our studies of the differentiation of cells.

Of equal importance are studies in epidemiology, including the investigation of environmental cancer. The National Cancer Institute has recently set up the first American laboratory devoted entirely to this subject. Carcinogenic factors in several industrial occupations are being studied, so that with the help of management, dangers will be minimized or eliminated. Data on climate, occupation, and other factors in the human environment are being assembled and correlated as rapidly as possible. This phase of our attack on cancer throws its light both ways, into the social sciences and likewise into the laboratories where the basic problem of the cancer cell is being studied. The rapidly increasing knowledge as to the causative agents of environmental cancer gives the distinct hope that definite progress may be made in the near future in discovering the inciting causes of the great bulk of cancers of so-called spontaneous type. It would be highly desirable if cancer were effectively reported in all states, as it is in some. I am glad to learn that a tumor registry has been established in Indiana. But even with the spotty statistics and case histories now available, much is being done, and the case histories that physicians can supply will be immediately and directly useful.

Studies in therapy, meanwhile, go forward on a wide front. The surgeons and radiologists have given us a steadily rising curve of success in those cases which do reach them in the earlier stages. You are familiar also with some of the more re-

cent therapeutic methods. Doctor Huggins' work with hormone therapy at the University of Chicago, the clinical use of nitrogen mustards, and the work of Dr. Sidney Farber in Boston with metabolite antagonists are recent developments of exceptional interest. Although these methods have produced only temporary remissions in certain forms of the disease, they are significant, as the first fruits of research into the mechanism of the cancer cell, and as signs of the growing integration I mentioned earlier.

Bearing in mind the old, useful cliché we learn in medical school—"You'll never diagnose a disease you aren't thinking about,"—the National Cancer Institute devotes a large share of its program to professional education. Two years ago the first grants were made to medical and dental schools to help intensify and integrate their cancer teaching. In seventy-four of the country's seventy-nine medical schools, and thirty-six of the forty dental schools, cancer training programs are now carried on with the aid of these grants. Indiana University Dental School is in this group.

One of the great needs in cancer control is for simplified technics of diagnosis. Various tests have been developed experimentally and are now undergoing clinical trial. At the National Cancer Institute reports upon cancer tests are being compiled, and those which show promise are being reevaluated with the aid of three state universities. At the University of Washington in Seattle we have set up the first screening center for cancer tests. That center will recommend promising tests to the Public Health Service clinic at Hot Springs, Arkansas, for clinical trial. The clinic is primarily for the diagnosis and treatment of venereal diseases, but a cancer study unit has been operating there for the past year and a half. Patients in the cancer-susceptible age groups have been screened for cancer by means of cytologic tests and physical examination. So far, cancer has been found in about 2 percent of the patients selected for study.

Training centers in the use of the Papanicolaou cytologic test also are being supported in whole or in part by Public Health Service grants. Only recently the state of Maryland, with the approval of the state medical society, began to offer interpretations of cytologic tests free to doctors requesting the service, a step previously taken by Hawaii and Idaho. At first used only in the diagnosis of cervical cancer, the Papanicolaou cytologic method is now being used with varying degrees of success in the discovery of cancer of the lungs, bladder, and prostate.

Biopsy and tissue examinations remain by far the most reliable diagnostic tests so far available, of course. These are the mainstays on which we all rely.

Some of the cancer control work in the Public Health Service, through grants to state health departments and other agencies, directly concerns the practicing physician. I believe that it would be an advantage to all clinicians to learn more about the services that their state and community health agencies—both public and voluntary—are offering. These programs are designed to help the physician discover and cope with cancer among his patients. New community programs of cancer detection return paying patients to the physician. The public health nurse is useful as a case-finder, also as a follow-up worker. Medical social workers and rehabilitation programs play their parts in the broad-scale effort. Yet none of the activities I have mentioned, nor all of them put together, are in any sense a substitute for the primary task of the examining physician.

The time has not come, if it ever comes, when average men and women can be counted on to recognize always the danger signals of cancer in themselves and come voluntarily seeking diagnosis and aid. For many years ahead there will be thousands who, for one reason or another—ignorance, fear, false feelings of shame, apathy, or other causes—will not voluntarily bring their symptoms to medical attention soon enough for cure. The specialist who is called on to render aid to the patient does what he can for the patient, but the case often comes to him when it is past cure.

The general practitioner, however, is usually the first professional person who has an opportunity to see the patient and recognize indications of cancer. There is no doubt that he can do more than anyone else to reduce the currently high death rate from this disease. He can intensify his search for cancer signs and symptoms, especially in patients who may seek his advice on other problems. And when he finds a suspicious symptom, he can make every effort to obtain prompt diagnosis and treatment for the patient. In his role as family counselor and painstaking, persistent examiner, the general physician is the key person in cancer control.

I know that the total number of additional cases which can be discovered by a single physician through such means during the course of a year will be relatively small. Yet if we assume that as many as one additional early cancer case could be discovered, on the average, by each practicing physician in the United States during the coming year, the total number of cases thus discovered in the early stages would be close to 150,000. If this effort were continued, the annual number of deaths would soon begin to drop.

The majority of cancers are situated where they can be found by the trained mind and developed senses of the physician, without a great amount of other diagnostic equipment. One of the most thorough studies in this field was made by Dr. D. P. Slaughter,[1] who published his findings in the *Illinois Medical Journal* last year. Basing his report upon the incidence of cancer in 100,000 white patients, Doctor Slaughter found that without the

use of instruments more than three-fifths of the total number of cancers can be seen or felt. The exact percentages were 21.8 percent visible, 29.3 percent palpable, 33.7 percent visible with instruments, and only 15.2 percent inaccessible. The inaccessible sites, of course, are the intestines, liver, pancreas, kidney and brain. But cancers found in the more accessible sites, such as skin, breast, cervix and rectum, far outnumber these.

It is not for me to advise you as to the nature of a cancer examination, except to point out that the attitude of the examining doctor is just as important as that of his patient. Many of us have in our subconscious minds—I know that I still have a streak of it—something of the old attitude that "Cancer is hopeless, so what's the use?" The answer to this one is easy. The people who take an aggressive, positive attitude toward finding cancer are increasing the percentages of cured patients; the man with a hopeless attitude cures none. The physician's attitude continues to be of the utmost importance beyond case-finding and diagnosis. I remember hearing someone say, "When any cancer is growing, there is just one day on which it begins to metastasize; that day may be tomorrow." In other words, it may sometimes be necessary to watch this disease, but it is easily possible to watch a day too long.

I hope that all of you will be able to see the film on "Cancer—the Problem of Early Diagnosis," produced jointly by the National Cancer Institute and the American Cancer Society, and shown at this convention. The combined experience of thousands of practicing physicians went into this film, which is the first of a series of five. The breast cancer film will be ready for showing in Indiana in October, another on oral sites in December. Films dealing with cancer of the lung, esophagus, gastro-intestinal tract, and skin will be ready in the spring.

Let me see if I can sum up some of the points I have tried to stress. The death rate from cancer can be sharply reduced at the present time, if physicians will use the knowledge and technics now available to discover more cases in the early stages. The medical profession is supported in this effort by a whole network of organized effort, public health and private agencies, research laboratories and clinical centers which the American people, through voluntary gifts and appropriated funds, have built for the battle against cancer. The physician, as he discovers more cases of early cancer, does more than help reduce the death rate. He is also contributing to the far-flung effort to find its cause and cure. He is taking part in one of the most significant and hopeful scientific movements of our time, towards the integration of the various disciplines in the growing concept of total health. To relate the routine chore of an office check-up for cancer to such philosophical speculation is a leap for the imagination; and it is precisely this mental exercise which I recommend, in closing.

This baffling disease, so closely associated both with the human environment of organized society and with the mechanism of the individual cell, has already led us to join social research with basic science and clinical medicine. The scientist has long since found that in order to make a real advance along the road of cancer research, he must often think beyond cancer. In somewhat the same way, I believe that it may help physicians if they think beyond the immediate, often vague, complaints which their patients bring to the office, to the possibility of cancer.

In our united effort the practicing physician, especially the general practitioner, is the key man. He will always be the key man. He makes the largest, most practical contribution to the task of bringing our several knowledges into a unified understanding.

REFERENCE

1. Slaughter, Danely P.: The Diagnosis of Accessible Cancer, Ill. Med. J., 93: 134 (March) 1948.

ARMY'S HEALTH IN 1949 BETTER THAN EVER BEFORE

"The Army's health was better in 1949 than it has ever been," Major General R. W. Bliss, Army Surgeon General, has announced. "The U. S. Army today is not only the healthiest army in the world, but the healthiest in all history."

Preliminary figures released by General Bliss show that the rate of admissions for 1949 was 128 per 100,000 strength per average day. "Admissions" in Army medical reporting include not only hospital patients, but also all persons relieved from duty because of illness or injury beyond the actual day of onset. The 1949 report shows an improvement in Army health for the fourth consecutive year since the end of hostilities and compares with an average wartime rate excluding battle casualties, of 202 admissions per 100,000 per day. Since then there has been a steady decline, the average daily rate being 178 in 1946, 174 in 1947, and 132 in 1948.

On page 309 of this issue will be found a list of organizations that have adopted resolutions opposing compulsory health insurance.

As of March 8, 1950, the following counties had failed to send any resolutions to headquarters office. It is hoped that by the time the next report is made these counties will be included in the list of those who have procured resolutions from organizations within their respective counties:

Adams, Brown, Franklin, Harrison, Hendricks, Pike, Ripley and Spencer counties.

INTRA-EPITHELIAL CARCINOMA OF THE CERVIX*

David A. Bickel, M.D.†

Carl S. Culbertson, M.D.†

SOUTH BEND

Doctor Bickel

The Authors:

Doctor Bickel graduated from Indiana University School of Medicine in 1921; received intern and resident training at Western Reserve University Hospitals, in Cleveland. He is a Fellow of the American College of Surgeons, Diplomate of the American Board of Obstetricians and Gynecologists. He is a member of the obstetrical staff of St. Joseph Hospital, and chairman of the obstetrical and gynecological staff of Memorial Hospital, South Bend.

Doctor Culbertson is associate director of the South Bend Medical Foundation; pathologist, Memorial Hospital, South Bend, and associate pathologist at St. Joseph Hospital, Mishawaka, and Elkhart General Hospital, Elkhart. He received his M.D. degree from Indiana University School of Medicine in 1937, and was a resident in pathology at Indiana University from 1938 to 1941. He is a Diplomate of the American Board of Pathology, a Fellow of the American Society of Clinical Pathologists and of the American College of Pathology.

Doctor Culbertson

THE detection of intra-epithelial malignant changes is so obviously significant in the control of cervical cancer that it has created widespread interest. The progress that has been made in the control of all cancer has been mainly through public educational programs and increased clinical alertness on the part of physicians regarding the extreme importance of its early recognition. It is now common knowledge, both to the physician and to the layman, that early detection is the most important factor in the cure of all cancer, and that early cancer is asymptomatic. Since we do not know the cause of cancer, there is little that we can do to prevent its development, and until such improvement is made in therapy, our most successful means of controlling the disease is by recognizing it in its incipiency.

The uterine cervix not only lends itself readily to clinical and pathological study because of its anatomic location, but it is one of the most frequent sites of the development of cancer in the female. The breast is the only organ where malignancy occurs as frequently. It has been estimated that one-half of all carcinomas in women develop in the uterine cervix and the breast; and that 65 percent of all pelvic malignancies are of the uterine cervix. The tragic situation is that with most adequate present-day treatment, the majority of women with clinically manifest cervical cancer die of that disease. This unfortunate plight, at the present, may be escaped only by instituting treatment earlier in the disease.

This discussion concerns the current concept of intra-epithelial carcinoma and the progress that has been made in its diagnosis and treatment. Many investigators since 1910 have described changes in the character and arrangement of cells within the cervical epithelium which are identical with those of clinical carcinoma; and now it is believed that these epithelial changes are not merely precursors of carcinoma but are carcinoma in its earliest stage of development.[1, 2, 3, 4, 5, 6] This idea has not been generally accepted, because in the histopathology of the lesions the classic characteristics of all malignancy, invasiveness, is not present. Such neoplastic changes have been described by a variety of terms: in situ, preinvasive, noninvasive, latent, potential and intra-epithelial carcinoma, and by some observers they have been considered only precancerous. An impressive group of cases (about twenty) with intra-epithelial changes only have been reliably reported, in which at some later period, months to years, invasive carcinoma made its appearance.[7, 8, 9, 10, 11, 12] The converse of this situation, a group of such cases, untreated, observed for years without the development of gross cancer, has not been recorded. Will these microscopic lesions inevitably develop into clinical cancer? Due to the long latent period of cervical carcinoma, it is quite possible that such microscopic neoplasms may be removed by minor surgical procedures, and many women may die of other causes before the development of the disease in its clinically recognizable stage. It has been

* Presented at the centennial session of the Indiana State Medical Association, at Indianapolis, September 27, 1949.

† From the South Bend Medical Foundation.

found by the examination of an abundance of pathological material that the occurrence of intra-epithelial malignant changes is about 3 percent, while the incidence of gross cervical carcinoma is about 1.5 percent, in all women over 30 years of age.[7] Whatever may be the exact relationship between intra-epithelial cellular changes and clinical cervical carcinoma, the histologic and clinical evidence indicates that such changes in the surface epithelium of the cervix are likely to develop into clinical carcinoma.

It is interesting to note that the average age at which intra-epithelial carcinoma has been found is about thirty-five years, while the average age of appearance of clinical carcinoma of the cervix is from six to twelve years later in life. This long interval between superficial development and invasiveness offers a unique opportunity for complete eradication of cancer.

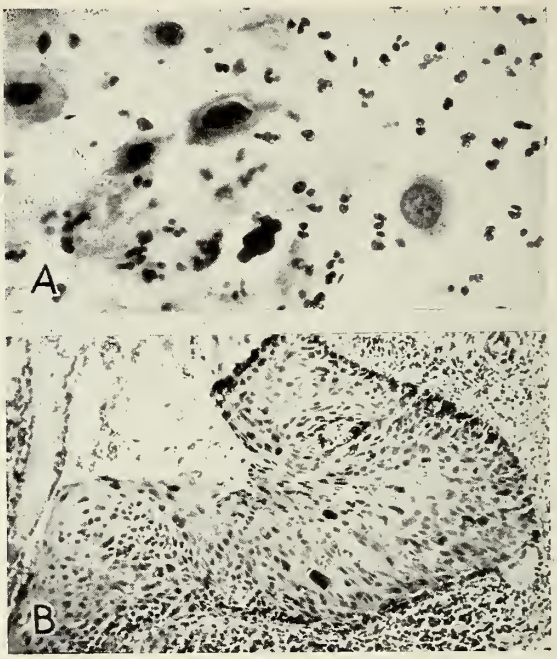
Almost every histologic study that has been made of early cervical carcinoma has revealed that it has its origin at or near the junction of the squamous and columnar epithelium.[13] This line of junction of the two types of epithelium may vary as to its location. It may be within the external os, but quite frequently extends to the vaginal surface of the cervix where a reddened area covered with columnar epithelium is observed, and is described as a congenital erosion. Because cervical carcinoma does usually develop in a limited area, an excellent opportunity is afforded to obtain cells or tissue for biopsy from an extremely early lesion.

Cervical cytology studies have been shown to be an invaluable aid in the detection of early malignancy of the female genital tract. They are a key to the problem, since it is through the study of cervical smears that the proper cases may be selected for further diagnostic procedures. The need for such a simple method of selection is obvious since biopsies as a part of a routine examination are neither practical nor desirable. Furthermore, a single random biopsy may lead to a false negative diagnosis. Our experience indicates that study of cervical smears which are properly taken offers an accurate and practical method of case selection.

METHODS AND RESULTS

The material in this report was submitted by physicians in the South Bend area from patients in their private practices. No selection or restriction of cases was attempted, and the material includes many smears taken as a part of a routine physical examination from cervices not considered suspiciously malignant; other physicians sent smears only from those cases with gross lesions or from cases with suspicious symptoms. Material for smears was scraped from the cervix with a spatula-like instrument (tongue blade) after the method of Ayre.[14] This procedure was followed because the surface epithelial cells are easily removed when

Figure 1, Case 1



(A) Cervical smear: Scattered cells with large atypical nuclei, 4 mm. (B) Cervical biopsy, 16 mm.; Intra-epithelial carcinoma; note large nuclei.

inflammation, ulceration and particularly malignancy are present. The use of aspirated vaginal material and smears made by cotton swabs was discouraged. Strict adherence to the Papanicolaou technique,[15] of immediate fixation in equal parts of ether and 95 percent alcohol before the smear had dried, was found to be essential for accurate work. Staining was done by the Papanicolaou method, although any method giving good nuclear staining with hematoxylin was acceptable. A simple request form with pertinent data was submitted along with the slides.

The smears were studied by a pathologist trained in cytologic interpretation. This part of the procedure is the bottleneck of the whole routine. While most of the slides may be surveyed adequately in a few minutes, not a few require an hour or more of study. In this feature the method suffers in comparison with the biopsy. (It has been said that the cytologic method is easy on everyone concerned except the cytologist.) However, the routine use of the *cervical* smear permits much more rapid study than did the original *vaginal* smear method, because malignant cells, when present, occur in much greater numbers in preparations taken directly from the cervix. Criteria for the recognition of malignant cells are, in general, similar to those used in tissue pathology, but competence in recognition and evaluation of both nonmalignant and malignant elements is gained only after long experience.[16] For this reason, widespread use of the method may be delayed until trained personnel is available in sufficient quantity.

When a report of malignant cells is submitted on a given case, the notation is routinely added: "This must be confirmed by biopsy." Adherence to this rule is imperative before radical measures of any type are carried out. The relationship of the smear to the biopsy is thus apparent; the smear offers a method of selection of cases for biopsy. The random biopsy may be negative, particularly in early cases, because it represents only a small fraction of the epithelial surface, whereas the smear gives a composite panoramic picture.[17] In many ways the smear and biopsy complement each other, a fact that has been well demonstrated by Graham et al,[18] who found either method alone to give a maximum sensitivity of 91 percent, but when used together a detection of 99 percent of all malignant lesions was achieved.

In an eight-month period from November 1, 1948 to July 1, 1949, cervical smears from 1,641 patients were satisfactory for study. The results were reported as positive, negative or equivocal rather than by Papanicolaou's five classes. An analysis of these cases is presented in Table I.

TABLE I

Total Number of Cases	1,641	
Positive-True (Confirmed)	43	2.62%
Positive-False	11	0.67%
Negative	1,580	96.28%
Negative-False	1	*0.06%
Equivocal	6	0.36%

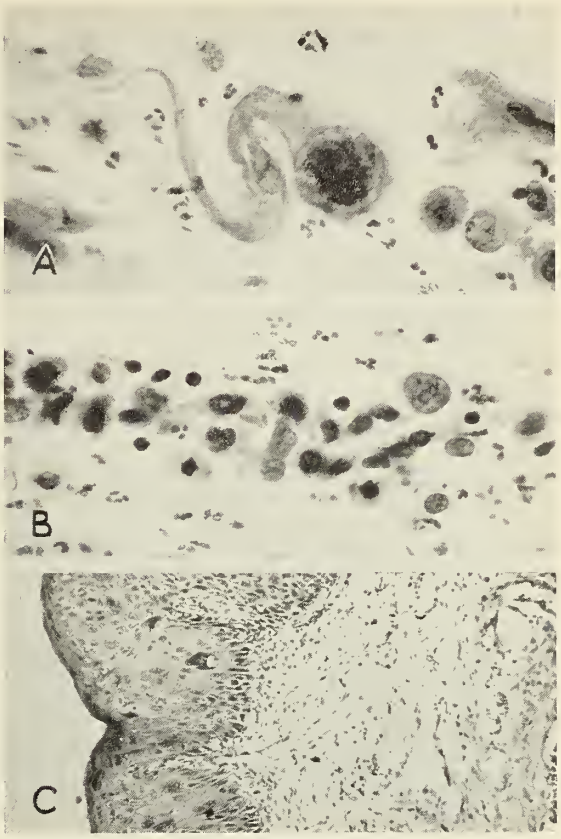
*2.3% of positives

In the case of an equivocal report, additional smears were requested, and a definite report was given from the repeat smear, if possible. Six equivocal cases in Table I have not been adequately followed for a definite diagnosis, and they remain equivocal.

False positives in this series include six cases which have had negative biopsies and negative repeat smears up to the time of this writing. All will be followed by additional smears at frequent intervals. The remaining five cases have not had adequate follow-up study for absolute confirmation of their false negative status, but they are included in this portion of the report for statistical purposes.

The one false negative was a case of adenocarcinoma of the uterine fundus. The decreased sensitivity of the method in the detection of endometrial carcinoma is evident in all published series.[16] It is apparent that a negative report should not cause delay in the performance of further diagnostic procedures if clinical features are suggestive of cancer. It must also be emphasized in regard to the false negative percentage in this report that since a small percentage of our negative cases have been biopsied and because the time interval since the completion of the study has been short, the actual false negatives may be greater than is indicated.

Figure 2, Case III



(A) Cervical smear: "Tadpole" type cell, 4 mm. (B) Cervical smear: Many cells with hyperchromatic, pyknotic, atypical nuclei, 4 mm. (C) Cervical biopsy, 16 mm.: Intra-epithelial cancer.

No accounting was done in this series in order to calculate the cost of the detection of a single case of unsuspected carcinoma. In other series this cost has varied from fifty to eight hundred dollars per case. If a yearly screening program of all women over the age of thirty was attempted, the cost for detection of the individual case would probably approach or exceed the higher figure.

An analysis of the true positives is given in Table II. The average age of the preinvasive, early invasive, and late invasive cancer in this series follows the same general pattern as other observers have reported; namely, a long interval (approximately eight years) between the preinvasive and the clinically invasive type.[19, 20]

TABLE II

	Number	Average Age
Intra-epithelial Squamous Cell Cancer of Cervix	16	39.4
Early Invasive Squamous Cell Cancer of Cervix	5	42.0
Late Invasive Squamous Cell Cancer of Cervix (Clinical)	16	47.8
Adenocarcinoma (Endocervix 1, Endometrium 6)	7	63.6

CASE REPORTS

I. W. F., age 39, complained of irregular menses since menarche; recent menorrhagia, metrorrhagia of moderate degree, and pain in sacrococcygeal region. Physical Examination: Moderate cervicitis and small cervical polyp. Was not believed to have been cervical cancer. 6-4-49, cervical smears positive; biopsy revealed intra-epithelial carcinoma. 6-25-49, hysterectomy. Intra-epithelial cancer and small fibromyoma.

II. W. F., age 27, gravida III, two months pregnant. Prenatal examination revealed moderate cervicitis and an erosion. 5-28-49, cervical smear positive. Conization 6-25-49, revealed intra-epithelial carcinoma.

III. W. F., age 28, came to physician because of obesity. Routine examination showed moderate cervicitis and erosion. Cervical smears positive 4-15-49. Biopsy 4-24-49, showed intra-epithelial carcinoma. Hysterectomy 4-28-49, showed early invasive cancer.

IV. W. F., age 38, came to physician for routine physical. Cervical smear taken from normal appearing cervix 6-16-49, was positive. Biopsy 6-21-49, showed intra-epithelial carcinoma. Hysterectomy 7-6-49, showed intra-epithelial carcinoma and small fibromyomata.

V. W. F., age 31, came to physician for treatment for obesity. Routine examination showed normal appearing cervix. Cervical smears positive 11-4-48. Biopsy revealed early invasive carcinoma 11-8-48.

VI. W. F., age 31, first seen by general practitioner 1-24-49, complained of metrorrhagia of mild degree, leukorrhea and burning on urination. Past history of four pregnancies including one stillbirth. Appendix and ovarian cyst removed six years ago. Physical Examination: Soft, friable cervix thought to be site of moderate cervicitis. Papanicolaou smears from the cervix 1-24-49, and 2-14-49, reported as positive. Cervical biopsy taken at latter date revealed intra-epithelial carcinoma.

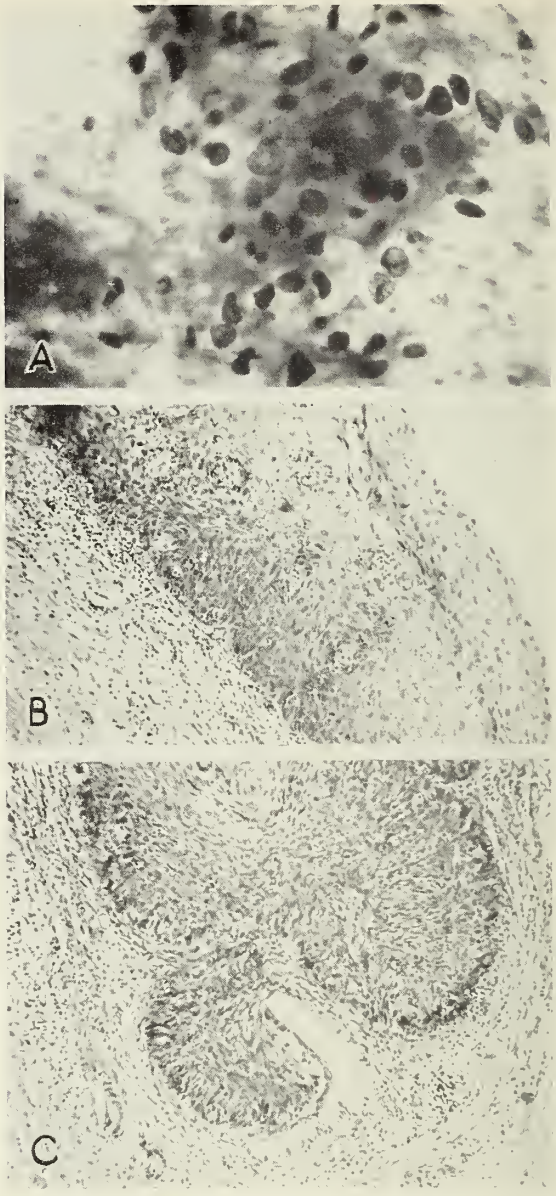
VII. W. F., age 38, reported for routine checkup. Previous subtotal hysterectomy. Cervix appeared normal. Cervical smear positive 4-7-49. Biopsy 4-16-49, revealed intra-epithelial carcinoma with questionable invasion. Cervical stump amputated 5-11-49, revealed squamous cell cancer with superficial invasion.

DISCUSSION

By far the most important part of this survey is the discovery by cytologic methods of twenty-one unsuspected early cervical carcinomas (sixteen intra-epithelial, five early invasive). This would seem to be ample proof of the merit of the procedure. Other statistical items in the report are of relative unimportance compared to this fact. The incidence of 2.6 percent positive cases may be explained in part by the fact that approximately half of them were cases of overt clinical carcinoma.

The incidence of the intra-epithelial lesion in this series is 1.0 percent. Similar results have been reported by others,[20, 21] although surveys based on the study of hysterectomy specimens have revealed incidences as high as 3.9 percent.[7, 9] Considerable variation exists, unfortunately, in the histologic criteria for making a diagnosis of this lesion, and for determining the presence or absence of invasion.[6, 7, 22] There is great need for correlated clinical and pathologic studies to give us more definite information concerning the course that a given lesion may be expected to follow. Controlled follow-up studies and death report statistics on cervical cancer, over periods of several years, will probably be necessary before the actual significance of the lesion is known. The current high interest in the subject is good assurance that clarification of the present controversial picture will be achieved.

Figure 3, Case IV



(A) Cervical smear: Atypical pyknotic nuclei in mass of dyskeratotic cells, 4 mm. (B) Cervical biopsy: Intra-epithelial carcinoma, 16 mm. (C) Cervical biopsy: Extension into cervical glands, 16 mm.

The first evidence leading to the diagnosis of intra-epithelial carcinoma does not come from the patient's subjective symptoms, but usually is the recognition of some slight cervical abnormality during a routine periodic examination in the physician's office. Again is emphasized the concept that early and curable cancer is asymptomatic. When the warning signal, vaginal bleeding, occurs

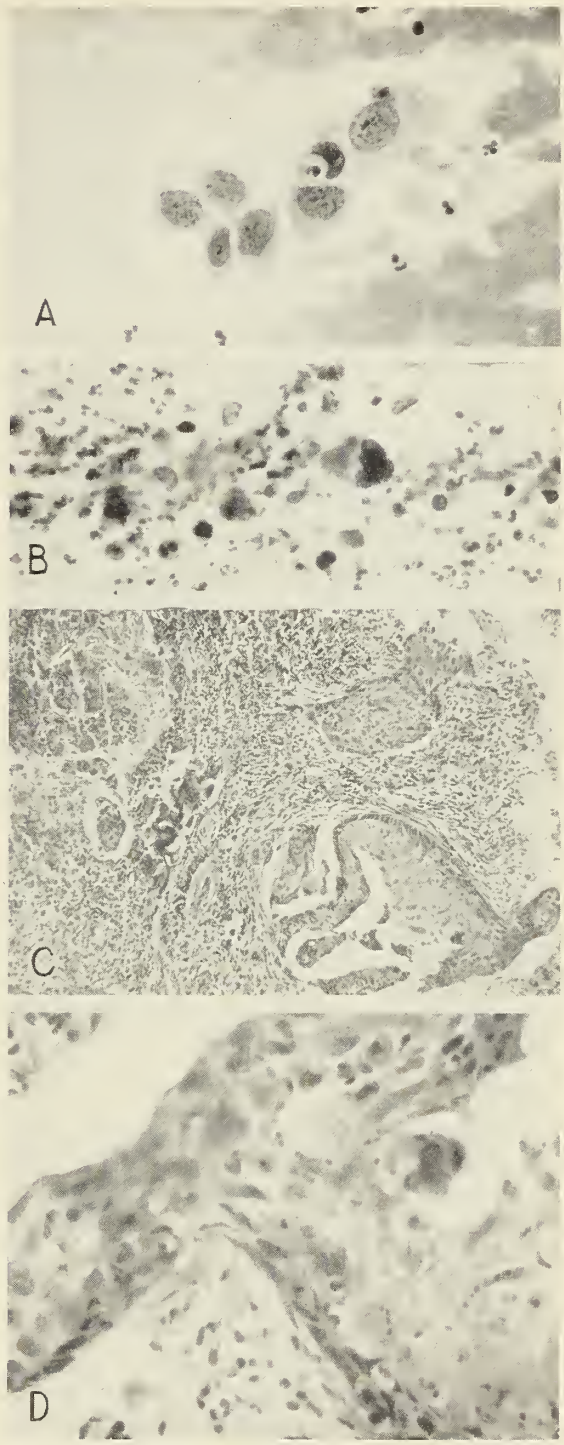
as the result of cervical carcinoma, invasion, destruction of tissue and ulceration have already taken place. A few patients with noninvasive malignancy may notice slight spotting following intercourse, and slight bleeding may also follow swabbing of the cervix during examination. When such bleeding occurs, it is usually caused by concomitant benign conditions such as erosion, eversion, laceration and cervicitis and is not from intra-epithelial cellular changes. These sites of benign involvement are important areas from which to remove tissue for biopsy. Clinical experience enables one to determine only whether the cervix is normal or abnormal and not to exclude malignancy in its early stages with any degree of accuracy. If cytologic smears reveal cancer cells, or cells which are suspiciously malignant, the removal of tissue for biopsy is imperative. In obtaining tissue for biopsy, it is important to have specimens of the whole zone of epithelium at the junction of the columnar epithelium lining the cervical canal and the squamous epithelium of the vaginal surface, and due allowance should be made for the variation in this junctional epithelial zone. Several instruments have been devised for this purpose, but this strip of tissue can usually be removed with a sharp knife. Adequate biopsy material is best obtained with the patient under anesthesia. The cervical canal should also be curetted at the time of obtaining tissue for biopsy. Areas of squamous metaplasia within the canal and also the endocervical epithelium itself may be the site of an early malignant lesion. The tissue curetted from the cervical canal also aids the pathologist in determining the presence or absence of invasion. It is to be remembered that the pathologist can only diagnose cancer if it is present in the biopsy material presented for microscopic study. It is most important to avoid the use of cautery in obtaining biopsy specimens. Removal of biopsy material by electrosurgical methods cooks and distorts tissue so that reliable histologic examination is frequently impossible. Cauterization following biopsy is also contraindicated as it complicates the picture if additional material is required for diagnosis.

TREATMENT

Because sufficient clinical observation is lacking, the treatment of intra-epithelial cervical carcinoma is not standardized as is the treatment of invasive or clinical cancer. In the main, the treatment of invasive cervical cancer is irradiation—with surgery reserved for a few chosen cases—and over 90 percent of the patients may be cured by radiotherapy if the disease is limited to the cervix. But unfortunately most cervical carcinomas are not now recognized while limited to the cervix. Until more extensive clinical observation determines the best method of completely eradicating intra-epithelial neoplastic tumors, the various recommendations regarding treatment must be considered. The methods of treatment recommended have varied from simple cauterization or conization to radical hysterectomy and intensive radiotherapy.

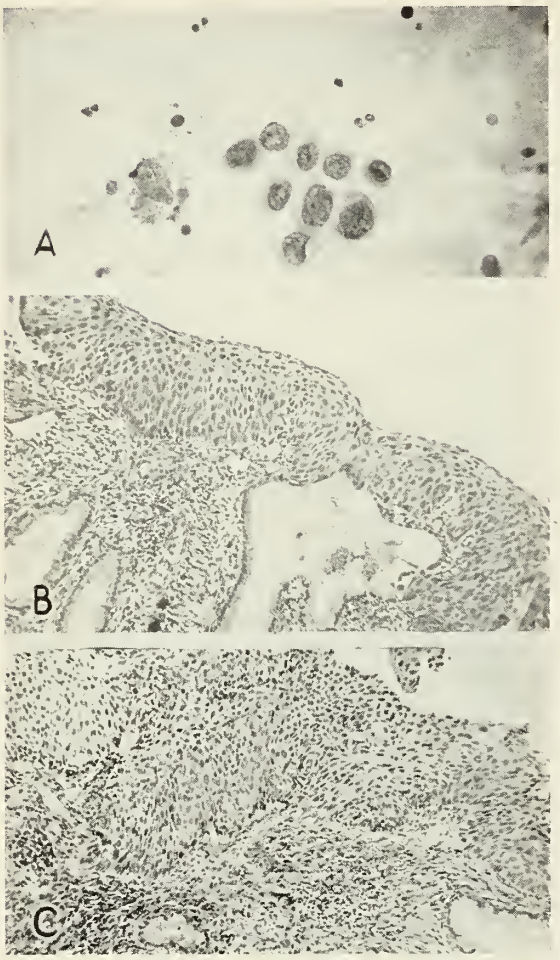
Cauterization or conization have been recommended as adequate treatment for these early le-

Figure 4. Case V



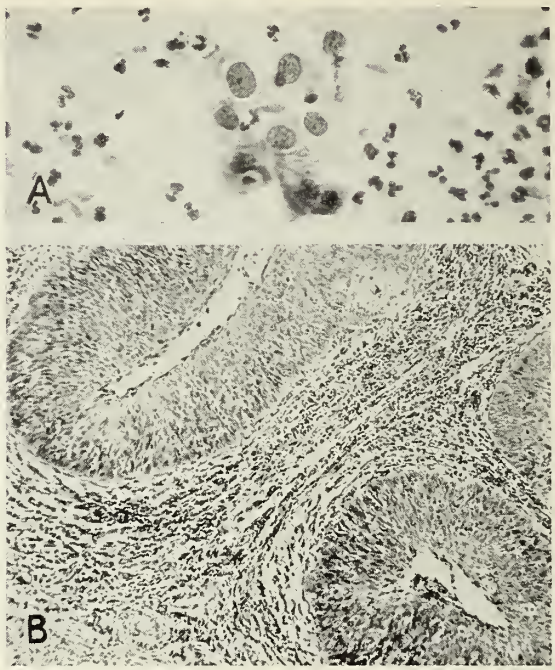
(A) Cervical smear: Clump of large atypical cells, 4 mm. (B) Cervical smear: Giant hyperchromatic nucleus with smaller atypical cells, 4 mm. (C) Biopsy: Superficial invasive carcinoma, 16 mm. (D) Biopsy: High power of (C) 4 mm.

Figure 5, Case VI



(A) Cervical smear: Group of large atypical cells, 4 mm. (B) Biopsy: Metaplasia and anaplasia in surface epithelium, 4 mm. (C) Biopsy: Intra-epithelial carcinoma.

Figure 6, Case VII



(A) Cervical smear: Clump of large atypical cells, 4 mm. (B) Cervical biopsy: Early invasive carcinoma, 16 mm.

sions. If it could be proved by complete histologic examination that only single areas of epithelial change existed, such treatment would be sufficient. The observation has been made that in very few cases where the cervix has been thoroughly cauterized has cancer subsequently developed.[23] It is likely that the zone of junctional epithelium with malignant potentialities, or even already existing malignant changes limited to the epithelium, is removed by this simple procedure. One may ask the question: Would not routine thorough cauterization of the cervix be a reasonable preventative measure in the control of cervical cancer? That question cannot be answered at present, but it merits some consideration. Since a few cases of gross cervical cancer have been reported following both cauterization and radium therapy, it is unsafe to rely on the adequacy of such simple measures where malignant changes already exist. Although irradiation would undoubtedly eradicate most of these superficial epitheliomas, there are many objections to its use: (1) The destruction of ovarian function is of some importance, especially since noninvasive lesions are observed in younger women than is clinically recognizable carcinoma. (2) Serious injury to normal tissue, such as proctitis, fistulae, pyometra and vaginal stenosis, occasionally results from intensive radiotherapy. (3) A few (probably 5 percent) of the cervical carcinomas do not respond to irradiation.

Amputation of the cervix is an operation which is rarely performed today, even for benign conditions. It has been largely replaced by cauterization, conization and removal of the cervix at the time of hysterectomy. Except in cases of involvement of a cervical stump following subtotal hysterectomy, there are few indications for its performance in the treatment of intra-epithelial carcinoma.

There are many reasons why total hysterectomy is the treatment of choice for intra-epithelial malignancy. The most conclusive reason is that in all cases that have been observed for an appreciable period there have been no recurrences of the disease following complete removal of the uterus. The largest group of such patients observed for a period of time is probably that of Galvin and Telinde.[24] They have a series of sixty-seven cases where the uterus was removed for noninvasive carcinoma that have been observed for a period of from six months to eight years without any evidence of recurrence. Since the average age of the patients who develop intra-epithelial carcinoma is over thirty-five, the majority of these women are near the end of their

reproductive period; therefore, preservation of the uterus for pregnancy is unimportant. By complete hysterectomy there is assured removal of all cervical epithelium as well as the removal of pathologic pelvic conditions which have been recognized or have been unrecognized preoperatively. It is of some importance to remove a small cuff of vaginal mucosa surrounding the cervix to be certain that no malignant tissue remains. In performing hysterectomy for this condition, one may leave one or both ovaries in younger women because it has been observed that the ovary is not a site of early metastasis of cervical carcinoma. That the remaining ovary may be a source of carcinogenic estrogen is of no real concern, since it has never been proved that estrogen has any effect on the development or growth of cervical carcinoma.

It should again be emphasized that hysterectomy is recommended for patients with intra-epithelial carcinoma and those with lesions showing minimal invasion only, and that radiotherapy is the generally accepted treatment for clinical carcinoma of the cervix. There are a few surgical centers where even early invasive and also advanced radioresistant cervical cancer is being treated by radical surgery. These operations are formidable and in the experimental stage, and are not procedures to be undertaken by the average surgeon.

When hysterectomy is performed for any condition, it is the established practice to remove the cervix. The cervix has no function either as an endocrine organ or as a supporting structure, and if not already the site of disease, it is tissue which is particularly disposed to both benign and malignant changes. It has been observed that 5 percent of all cervical cancers have developed in a cervical stump that has been left following subtotal hysterectomy, or malignancy was present and unrecognized when hysterectomy was performed.

Even as a treatment for intra-epithelial malignancy, one is reluctant to advocate the extension of the indications for hysterectomy. Already many hysterectomies are performed without symptoms or pathology to justify the operation. It is therefore essential in the management of intra-epithelial or noninvasive cervical carcinoma to be guided by a thorough and careful examination of adequate biopsy tissue by an experienced and competent pathologist. Adequate tissue usually means all of the epithelium of the junctional zone. It is preferable to remove this tissue by knife dissection. And a competent pathologist is one who is not interested in enlarging the field of indications for pelvic surgery. Here we have on one hand an excellent opportunity to eradicate cancer in its preinvasive stage; and on the other hand, we have the danger of unnecessary mutilating procedures based on false pathologic interpretation.

SUMMARY AND CONCLUSIONS

1. There is now considerable histologic and clinical evidence which strongly suggests that cellular changes which are identical with invasive carcinoma, but are entirely within the surface epithelium, are an early stage of cervical carcinoma. But more study is required before we can be certain that intra-epithelial neoplasms will inevitably become invasive tumors.

2. The majority of cervical carcinomas arise near the external os at the zone of junction of the columnar and squamous epithelium. This fact furnishes a lead to where biopsy material may be taken to detect early malignant changes.

3. Sixteen cases of intra-epithelial carcinoma of the cervix and five of early invasive carcinoma were discovered in a study of 1,641 cervical smears during an eight month period.

4. Cervical cytology is a sensitive and practical diagnostic method; it is the key to the selection of cases which need further diagnostic work. Confirmation of the results of positive smear examinations must be done in every case by accepted histologic methods.

5. Although clinical observation has not been sufficient to standardize the treatment of intra-epithelial carcinoma, the most dependable, presently-known method of eradicating these early lesions is by total hysterectomy. The effectiveness and safety of less radical measures such as cauterization are not yet established.

6. If the control of cervical cancer is to be more effective, we must not only educate women to be examined when they have abnormal vaginal bleeding, but we must earnestly and persistently advocate periodic pelvic examinations. When abnormal vaginal bleeding occurs, malignant invasion with destruction of tissue and ulceration has already taken place, and in many instances we are no longer dealing with an early or curable lesion.

7. It is the duty of the physician to become familiar with, and also to use every means of detecting cervical cancer in its early stages.

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CARCINOMA OF THE LUNG

WAYNE CARSON, M.D.

INDIANAPOLIS

HISTORY

IN 1933 Evarts Graham reported the successful removal of the entire left lung of a human subject who was suffering with carcinoma involving the left upper lobe bronchus. Soon afterwards successful complete pneumonectomy was also reported by Rienhoff and by Overholt. Prior to this time the treatment of cancer of the lung had been chiefly palliative, and nowhere in American medical literature was there a record of successful pneumonectomy for primary malignancy.[1]

These reports stimulated workers sufficiently so that within the past seventeen years the literature on surgical treatment of cancer of the lung has come to compare favorably with that concerning cancer of the stomach.[2] Mass ligation of the hilum of the lung was used in the early days, but, because of extremely high mortality and morbidity, this type of operation was soon discarded for individual dissection of the pulmonary vessels and main bronchus. The immediate operative mortality remained high for awhile, and in 1939 Ochsner and De Bakey[3] collected eighty-six cases of total pneumonectomy (which included seven of their own) for cancer of the lung with a mortality of 63.9 percent (fifty-five deaths). Of these fifty-five deaths, all but five occurred within the first thirty days after operation. As experience increased there was a constant decrease in the immediate operative mortality and the five-year survival rates began to look encouraging.

Beginning in 1948 sufficient time had passed for numerous surgeons to report on large groups of cases. Some of the statistical data from four such reports have been combined and are presented as representative of the present status of the surgical treatment of cancer of the lung. Adams (182 cases),[4] Burnett (429 cases),[5] Ochsner et al. (548 cases),[6] and Rienhoff (502 cases),[7] have recently reported on a total of 1,661 cases of carcinoma of the lung. In only 476 of these patients was resection carried out; in the remaining 1,185 the clinical findings contraindicated any operation, the patient refused operation, or upon exploratory thoracotomy the findings were such that resection was considered inadvisable. Such figures indicate that in this large group of patients only one out of every three or four individuals suffering with lung cancer

reached the surgeon early enough to be treated by partial or complete pneumonectomy. The average postoperative mortality in the 476 cases (within thirty days of the operation) was 23 percent. It is emphasized that this figure includes all the deaths in the early days when the reported mortality rate was close to 70 percent—actually the present-day operative mortality is running much less than 23 percent. Jones[8] recently reported fifty-two consecutive cases with an operative mortality of 4 percent—a figure that would seem to compare favorably with major resection surgery for cancer in other fields. Of those 476 cases, approximately 30 percent (118 persons) are listed as alive at the end of five years. When it is remembered that the majority of these patients are in the fourth to the sixth decade of life, with the usual attendant degenerative changes, such a survival rate represents an amazing change of outlook in seventeen years' time. One other point stands out prominently: the best chance for improvement in the five-year survival rate lies in a drive for earlier diagnosis. All of the writers agree on that point.

Several other interesting statistical observations have been made, e.g., "a patient who lives through the second year after operation has a good chance of being alive at the end of five years."[6] "Regardless of the duration of symptoms, a patient who has a resection and survives the operative procedure has approximately a 60 percent chance of surviving for one or more years."[4]

ETIOLOGY

Based on experimental evidence, there is no information that throws any light on the cause of cancer of the lung. Several interesting controversial questions have arisen. Is cancer of the lung definitely on the increase—or is the reported increasing incidence due to improved diagnostic procedures and more careful recording of causes of death? Assuming that chronic irritation over a long period of time is an important causative factor, what part does cigarette smoking play in the incidence of the disease? Is there an etiological clue in the fact that there are six male patients for every female patient and that the survival figure for females is better than that for males? Considerable public interest has been created with regard to smoking by an article in the January 1950 issue of the *Reader's Digest* (page 1), in which Dr. Evarts Graham says: "it is curious how very few nonsmokers develop lung cancer." Doctor Ochsner follows in the same article with "Twenty-five years ago I saw only one cancer of the lung in four years. In the last 15 years I have seen thousands. I am convinced that there is a definite relationship between smoking and cancer of the lung." In the February 3, 1950 issue of the *U. S. News and World Report* there is an article on experiments claiming that cancer-susceptible mice exposed to cigarette smoke showed no more tendency to develop lung cancer than a similar control group of "nonsmoking" mice in a 300 day test period.

There will probably be further firing from both sides.

DIAGNOSIS

An important point to keep in mind about the diagnosis of cancer of the lung is that no group of symptoms or physical findings, no clinical laboratory aids or surgical diagnostic maneuvers will insure a correct answer 100 percent of the time. As experience is improving the surgical statistics, so it is increasing the accuracy with which suspected cases are "worked up." There are many symptoms that should arouse suspicion of lung neoplasm, and some of the more common ones are: (1) new cough with or without sputum, or change in character of a cough of long standing; (2) hemoptysis of all grades; (3) chest pain; (4) persistent low grade pneumonitis (after initial improvement following the administration of antibiotics) or recurring "virus pneumonia"; (5) weight loss; (6) dyspnea; (7) wheezing; and (8) fatigue with vague chest discomfort. If a cancer is responsible for such symptoms the majority of cases will show some type of abnormality on x-ray. In Rienhoff's series of 502 cases[7] the x-rays were positive in every instance. Gibbon,[2] however, describes a case of hemoptysis in which chest x-rays were negative though bronchoscopy showed a squamous cell cancer growing in the left main stem bronchus.

With suggestive symptoms and an abnormal x-ray, the sputum, if present, should be examined for organisms (including the tubercle bacillus) and for tumor cells. In every patient in whom cancer is suspected bronchoscopy should be done. In approximately 40 to 50 percent of the cases of cancer the growth will be accessible for biopsy. Sometimes if the disease is far enough advanced there will be palpable supraclavicular or axillar nodes which, on biopsy, will confirm the diagnosis.

By involving the main stem bronchus, with resulting cough and hemoptysis, a solitary metastatic growth can closely simulate bronchogenic carcinoma. Two cases in which metastatic lesions were mistaken for primary growth preoperatively have been reported by Freedlander and Greenfield.[9]

In dealing with the cases with negative bronchoscopic findings the problem becomes more complex. In 1946 Herbut and Clerf[10] described their experience with the study of bronchial secretions obtained through the bronchoscope from the area of lung suspected of harboring a neoplastic process. By staining the secretions, using the Papanicolaou method, they found desquamated cancer cells in a large percentage of the cases later proved to have carcinoma of the lung. They concluded that with the aid of such a procedure the diagnosis could be established with certainty in a

large proportion of suspected lung cancer patients and would be of particular value in instances in which the bronchoscopic findings were negative. If no secretions were available for collection, the bronchial segment of the suspected area of lung was washed with saline and the washings studied. Following this report numerous articles have appeared dealing with the examination of secretions obtained both with the bronchoscope and on coughed-up sputum. The evidence is accumulating that cytologic examination of bronchial secretions is a valuable means of increasing the accuracy of the diagnosis of cancer of the lung.[11] It is emphasized that the reliability of the results depends largely on the experience of the cytologist. Exploration of the chest is strongly recommended by many surgeons for all suspicious cases in which tumor tissue is not accessible for biopsy at bronchoscopy. Some place exploratory thoracotomy in the same category with exploration of the abdomen and feel that complications are actually less apt to occur.[7] Even at exploration experienced operators remark about the instances in which nonmalignant lesions have been interpreted as cancerous and cancers erroneously regarded as benign. Excision of a portion of grossly suspicious lung tissue or of regional lymph nodes for immediate frozen section study often decides whether a lesion is malignant or not. However, because a certain amount of inflammation often surrounds the neoplasm and enlarges the regional nodes, it is easy to mistake nonmalignant inflammatory tissue for cancer tissue in taking the biopsy.

Brewer,[12] in discussing a group of nonmalignant lesions which closely resembled cancer, points out that it is better to err on the side of resection, because in most instances even if the lesion is not carcinomatous it is still likely to be a pathological process which is best treated by excision.

TREATMENT

Once the diagnosis of cancer of the lung has been established, removal of the entire lung, or that segment of the lung involved by the growth, is the treatment of choice. Most surgeons favor complete pneumonectomy in all cases. Neuhof[13] and Adams[6] have reported satisfactory results with lobectomy in certain selected peripherally located tumors.

Ochsner et al.[2] emphasizes the desirability of employing resection more often even though the exploratory findings show that the neoplastic process has extended grossly beyond the lung parenchyma. They consider such resections as palliative and feel that the follow-up results in these cases have been very encouraging. Mentioned as contraindications to exploration are the presence of distant metastases, the obvious involvement of the trachea or carina, or the presence of malignant cells in the pleural fluid. Relief from the obstructive symptoms of the growth, together with the elimination of the accompanying chronic sepsis, is well worth the operative hazards although there is no hope of a cure.

In carrying out resection in patients with growth beyond the lung, excision of a portion of the pericardium with ligation of the pulmonary veins flush with the left auricle,[14] suturing of the auricle, and resection of a part of the diaphragm or thoracic wall have been employed.[6]

Personal experience with the surgical treatment of lung cancer includes twelve complete pneumonectomies, with three deaths within thirty days of the operation. Eight of the patients resected have survived, with the longest survivor still living at the end of two and one-half years. In three instances partial resection of the pericardium was necessary. In another the left auricle was sutured. All of these patients upon whom this palliative operation was performed are living and active, and to date the longest period of postoperative survival is six months.

The management of the many patients who are considered inoperable for one reason or another, or who have been explored without resection, is a trying problem for everyone concerned. The relief of pain and amelioration of the disagreeable symptoms such as cough and hemoptysis are sometimes aided by the use of palliative x-ray treatments. Methyl-bis (one of the hydrogen mustards), given intravenously, has also been used with favorable results according to some writers,[15, 16] but it is a toxic drug and must be employed with caution—preferably only when the patient is hospitalized.

SUMMARY

An outline of the development of the surgical treatment of primary cancer of the lung has been presented. Statistical information most likely to interest the general practitioner has been included. It seems worth-while to emphasize particularly the value of earlier diagnosis as one of the ways of improving the five-year survival rate. Personal experience with complete pneumonectomy in the treatment of cancer of the lung consists of twelve cases with a postoperative mortality of 25 percent.

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THE HUGGINS' TEST FOR CANCER†

Jack L. Eisaman, M.D., Louis A. Schneider, M.D.,

and Richard E. Berger, M.Sc.*

BLUFFTON

SINCE the original report by Huggins,[1] great interest has been aroused in the use of thermal coagulation of protein as a possible aid in the diagnosis of cancer. A series of 254 Huggins' tests (Least Coagulable Protein Concentration) was performed in the Caylor-Nickel Clinic on 239 patients admitted for routine diagnosis.

CONFIRMED MALIGNANCY

Seventy-seven of these patients had a diagnosis of cancer confirmed by pathological examination. Of this number, the Huggins' test was positive in forty patients and negative forty-one times in thirty-seven patients.

TEST POSITIVE—MALIGNANCY PRESENT

The forty positive tests in known cases of cancer were found in twenty-three different malignant conditions. Cancers of the gastrointestinal tract included: stomach 1, pancreas 1, colon 4, gallbladder 1, primary in the liver 2, and secondary cancer of the liver 2. Cancers in the genitourinary tract included: kidney 1, bladder 3, prostate 1, testes 1, cervix 3, breast 6, ovary 3, and a retroperitoneal dermoid containing a papillary adenocarcinoma. Cancers in the respiratory tract included the left antrum 1, lung 1, and metastatic cancer of the pleura 1. The miscellaneous conditions included a melanoma 1, basal cell cancer of the skin 1, lymphosarcoma 1, metastatic adenocarcinoma of a lymph node 1, abdominal paracenteses fluid 1, and abdominal mass, origin unknown 2.

TEST NEGATIVE—MALIGNANCY ERADICATED?

The forty-one negative Huggins' tests in thirty-seven patients who have had a diagnosis of cancer included nineteen conditions. The shortest postoperative period in which the test was negative was two months in a cancer of the ovary; the longest period was eighty-two months in a cancer of the breast. The longest negative test case was a twenty-two-year post-irradiation skin cancer.

Eight of these thirty-seven patients had gastrointestinal malignancies. There were three cancers of the stomach, two of the rectum, and three of the colon. Three tests on two different patients in this group were definite failures, in that they were negative before operation; although in both cases the test became positive five and six days following surgery. The other negative cases were from four months to two years postoperative without clinical evidence of recurrence.

Eleven of the thirty-seven patients had cancer of the breast. There was one false negative in this group. This patient had a negative test in the presence of metastatic adenocarcinoma of the breast throughout both lung fields. A positive test was obtained in this case two months later when her lungs were more involved. One case had a positive test three months postoperative and two months post-irradiation, and negative four months

† From data presented in the Scientific Exhibit of the centennial session of the Indiana State Medical Association, in Indianapolis, September 26, 27, 28 and 29, 1949.

* From the departments of medicine and laboratory, Caylor-Nickel Clinic.

postoperative. The other negative cases ranged from four to eighty-two months postoperative without clinical evidence of recurrence.

In the genitourinary system there was one case of cancer of the prostate, two cases of cancer of the bladder and three cases of ovarian cancer. The case with cancer of the prostate was controlled for two and one-half years on stilbestrol. However, a cystoscope could not be introduced due to obstruction; and at this time he had a negative test, a false negative. One bladder cancer had a positive test one week preoperative and a negative Huggins' test two months postoperative. Another bladder case had a negative test fifty-two months postoperative without cystoscopic evidence of recurrence.

One ovarian case had extensive peritoneal spread with ascites. However, two and four months postoperative the Huggins' test, pelvic and abdominal examinations were negative. Another case of ovarian cancer had a negative test and no clinical evidence of recurrence seven months postoperative. The third ovarian cancer had negative tests and physical findings eight and twelve months postoperative.

There were five cases of squamous cell epithelioma of the skin and orifices: cervix 1, throat 1, nose 2, and vulva 1. In the cervix case the test was positive five months post-irradiation without positive pelvic findings, but was negative seven months post-irradiation. Prior to treatment, the throat case had suggestive signs of spread to the submandibular glands but the test was negative twenty-eight months post-irradiation. The nose cases had negative tests thirty months postoperative in the one case and twenty-two years post-irradiation in the other. The case with vulval epithelioma had a negative test eight months postoperative. None of the five cases showed clinical evidence of spread or recurrence.

The miscellaneous cases gave us the greatest number of false negatives. The first case is one of malignant melanoma of the choroid. Five months postoperative the test was negative, the urine was negative for melanin and there was no clinical evidence of local or distant spread. We called this a false negative; it is debatable whether it should be so classified. The next case is an atypical lymphosarcoma with a negative test. This is also classified as a false negative. The case of retroperitoneal hemangioendothelioma with pulmonary metastasis of eleven or more years' duration gave a negative test which is, of course, a false negative. Hodgkin's disease gave us a negative test two months post-irradiation when there was no clinical evidence of disease. However, we called this a false negative because of the inevitable outcome. Retinoblastoma also gave a false negative. A case of metastatic adenocarcinoma of a lymph node gave us a false negative. A truly negative test was obtained in a fifty-one month postoperative carcinoma of a submaxillary gland.

TEST NEGATIVE—MALIGNANCY CLINICALLY ABSENT

Negative results ran the gamut of general hospital diagnoses. One hundred and ten negative Huggins' tests were obtained in forty-three conditions without definite evidence of cancer. These cases included the gastrointestinal, genitourinary, cardiovascular, skeletal and respiratory systems, thyroid gland, and miscellaneous conditions. In the gastrointestinal group there were two cases of gastric ulcer, three of chronic gastritis, as well as three of duodenal ulcer. Prominent in this group were seven cases of cholelithiasis and seven of chronic liver disease. In the genitourinary group chronic cervicitis and chronic prostatic disease head the list. Of the group tested with cardiovascular disorders, arteriosclerotic heart disease ranked highest. In the other systems arthritis was the largest group checked.

TEST POSITIVE—MALIGNANCY CLINICALLY ABSENT

Sixty-three positive Huggins' tests were obtained in thirty-four conditions without clinical evidence of cancer. You will note that our greatest number of false tests were false positives. This group included the gastrointestinal, genitourinary, cardiovascular and skeletal systems, thyroid gland, and miscellaneous conditions. The gastrointestinal tract included: Gastric ulcer 1, duodenal ulcer 4, hypertrophic gastritis 3; and among the other conditions: cholelithiasis 3 and chronic liver disease. In the genitourinary system, mazoplasia, chronic salpingitis and chronic prostatitis were of major importance. There were three cases of arteriosclerotic heart disease. The thyroid gland is very interesting, in that false positives were obtained in both hyper- and hypothyroidism, as well as thyroiditis. It is noteworthy that the two cases with hyperthyroidism, giving positive tests before surgery, had negative results a week after surgery. Arthritis of various types gave our greatest number of false positives; of the miscellaneous group, bronchiectasis and diabetes are important.

		Malignancy Pathologically Confirmed	Malignancy Clinically Absent
Test Positive	Tumor Present	40	
	False Positive		63
Test Negative	Possible Cure	30	
	False Negative	11	
	Malignancy Clinically Absent		110
		81	173

SUMMARY

We feel that the Huggins' test is a valuable laboratory aid. We agree with Doctor Huggins that it is not a cancer test, but it probably mirrors an alteration of protein metabolism which is not detected by other tests. It may be a valuable adjunct in the diagnosis of cancer.

In our experience used as a screen, false positives occurred in 25 percent of the total tests done. These were mainly arthritides, thyroid diseases, mazoplasia, duodenal ulcer and gastritides.

The test was 71 percent accurate. This consisted of the 110 negative tests in negative patients 43 percent; thirty truly negative tests in the patients apparently cured of cancer 12 percent; the forty positive tests in the cancer cases 16 percent.

False negatives occurred in eleven cases (4 percent of the tests). These were considered false in some of the cases because the test was negative in incurable malignant conditions.

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Clinical Pathological Conference

Presented by the Staff of St. Elizabeth Hospital
LaFayette, June 8, 1949

J. M. McFadden, M.D., Pathologist*

R. J. Duran, M.D., Resident in Pathology

General Statement: Mrs. R. M., a 47-year-old, white female, was admitted to the hospital May 10, 1949. Chief complaint: Convulsions. Present illness: The patient was in fairly good health until November, 1948, at which time she experienced a convulsion. The convulsion was described as consisting of tonic contractions, two minutes in duration, followed by an unconscious period of 45 minutes. Approximately six weeks later a second attack occurred, which was more severe. She became bedfast in January of 1949. She did not seem as alert as usual but had no specific complaints. The attacks increased in number but the period of unconsciousness lessened. Convulsions were daily just prior to admission. There had been some weight loss but the exact amount was not known.

Physical Examination: Revealed a poorly-nourished, poorly-developed, darkly-pigmented, white female, appearing very weak and listless. Blood pressure on admission was 120/80, pulse 100, temperature 97°, and respirations 18. Examination of the mouth revealed recent extraction of teeth; lungs normal. Cardiovascular: There was an apical systolic murmur present. Genitourinary system: Pelvic examination disclosed a purulent discharge, a third degree retroversion of the uterus, and cervicitis. A smear was made of the discharge. Neurological examination: In general, the muscle power was weak in the extremities. Patient flexed the left leg and held it flexed at the knee and hip by choice. A detailed neurological examination was performed but the findings recorded here are only those which we considered pertinent.

Laboratory: On admission, urinalysis and Mazzini were negative. Blood analysis showed 90 percent hemoglobin, 4,760,000 red cells, 14,300 white cells, differential 4 percent stabs, 4 percent eosinophils, 83 percent segmented neutrophils, 87 percent total neutrophils, 9 percent lymphocytes. Sedimentation rate 3 mm., hematocrit 50 mm., N.P.N. was 22 mg. percent, blood sugar 88 mg. percent.

Clinical Course: Seizures were frequent during the hospital course, varying from one to three a day, and usually precipitated by excitement, continued to be entirely tonic contractions, and varied in duration from slightly less than one minute at the onset of the hospital course to four minutes for the last seizure. During the last few seizures the patient was incontinent of urine and feces, and frothy sputum exuded from the mouth. On the day following admission x-rays of the skull were made which revealed no definite abnormalities. A spinal tap was performed on the same day and an initial pressure of 80 mm. of water was recorded, with fluid clear and closing pressure of 60 mm. of water. Queckenstedt was negative. Wassermann and Gold Curves were negative. Sugar was 46 mg.

* Editor of this conference report.

percent, total protein 42 mg. percent. There was one poly in the fluid. Dilantin and phenobarbital were started on May 11. A vaginal smear on May 13 revealed many small gram-negative cocci in pairs, some intracellular and some extracellular. Following this report, duracillin, 1 cc. b.i.d., was started. On May 13 x-ray of the chest revealed a density, measuring approximately 3 cm. in diameter, adjacent to the right hilus, with exaggeration of bronchovascular markings and of both lung fields. A flat plate of the abdomen at the same time disclosed almost complete destruction of lumbar III vertebra with secondary collapse. A repeat of these two areas on May 16, with varied technique, revealed essentially the same findings. As stated, the convulsions became more severe. Temperature remained approximately normal with pulse rate fluctuating. The patient expired on May 23, 1949. An autopsy was granted and performed.

Dr. DuBois:* I saw this patient after she came to the hospital. She was from Colburn, and Doctor Wagoner from Delphi had seen her several times at home, and he sent her into the hospital. Since I had known the family previously, they called me to take care of her. I really don't have anything to add, except that the patient was unable to give a history and this history was obtained from her husband. I never saw her in one of these seizures. As described to me, they were more or less typical of epileptic seizures, and following the seizure she would go into a more or less sleepy stage, but she was sleepy all the time. She wouldn't answer questions and did not respond in a sensible manner. She had never had seizures before until, of course, the age of 47, and the only other findings were the facts that she would not eat and had lost considerable weight.

*Doctor Buhrmester**:* I want to talk about epilepsy. This patient, a 47-year-old, white female, experienced convulsions. Epilepsy is a syndrome of the cerebral cortex, of course, motor or sensory cortex, or both, and it is a cortical dysrhythmia. It is a firing of the cortex. If one draws a section, with the motor cortex and sensory cortex shown, a sensory aura results from the dysrhythmia or firing of this area and then the fire proceeds to the motor area, as a rule, and a convulsion results. It is all a dysrhythmia as shown by the electroencephalogram. There are three types: grand mal, which on the electroencephalogram shows a wild picture, fast increased voltage waves; and petit mal, which is an arrest phenomenon, clinically of short duration, one to two seconds. The electroencephalogram shows a spike and plateau wave pattern. There is also psychomotor epilepsy, which is what we used to call the epileptic equivalent, the dream state; and in that state, patients will commit violence on themselves or others, or wander around in a dazed fashion, or go through all kinds of repetitive movements. Professor Frederic Gibbs, University of Illinois, was the first to diagnose psychomotor epilepsy accurately by the electroencephalogram and demonstrated it to be a discharge in one temporal lead at least. (The downward deflection is a positive voltage deflection, electrically.) You should know about that because the treatment is different. The treatment for petit mal also is different from grand mal. There are a number of new drugs coming out which improve petit mal and psychomotor epilepsy. In some cases when the psychomotor epilepsy is controlled they will develop a psychosis, any kind of psychosis, manic phase, depressed phase, schizophrenic phase. There is an antagonism between certain diseases, as you know; we give artificial epilepsy to manic-depressives to cure them of psychosis. An epileptic very rarely develops an affective psychosis. There is an antagonism there. When a patient is cured of psychomotor epilepsy, he will sometimes develop a psychosis. His epilepsy has kept the psychosis under the surface. Two series of cases of psychomotor epilepsy have been operated upon in Chicago. Professor Percival Bayley has gone in and ablated the anterior third of the temporal lobe. Fifty percent of the patients have improved. Now, as far as the electroencephalogram goes, we used to think that we had to precipitate a fit, you know, oftentimes, to get the positive electroencephalogram. We would have the patient hyperventilate. Professor Gibbs has found that at least 80 to 90 percent of patients with epilepsy will show characteristic seizure discharges in the electroencephalogram when asleep. If the patient cannot sleep, spontaneously, seconal or nembutal is given.

I have been talking about constitutional epilepsy. There isn't any evidence in this case that it is constitutional epilepsy. She was too old, in the first place, and there is no positive family history.

Then, of course, there is a developmental epilepsy, an aplasia of the whole brain, which will cause fits, and one usually finds mental deficiency in addition, and she apparently didn't have that at all. Concerning traumatic epilepsy, there is no evidence of that. If one has had an injury and has had a scar, an epileptogenic focus is set up. The scar doesn't amount to anything. Removing the scar is valueless because the cortical cells are dead under the scar. It is the margin where the cells are abnormal and fire the rest of the cortex, and that, of course, gives Jacksonian seizures, which is epilepsy; with a march the firing marches all over the brain. Now, how does it march? Well, Professor Gibbs likewise likens the thing to a fireplace. The wall is covered with soot, the fire burns normally but occasionally a glowing, burning spot develops in the soot, a branching, fiery path springs from it and then the soot burns all over the fireplace; it

* R. B. DuBois, M.D.—Lafayette physician and Staff member, St. Elizabeth Hospital, Lafayette.

** H. C. Buhrmester, M.D.—Internist at the Arnett Clinic and Staff member, St. Elizabeth Hospital, Lafayette.

just marches to extend all over the fireplace. But how does the spread occur from one hemisphere to the other? It occurs fairly simply through the corpus callosum, which is a great white fiber tract connecting the two cerebral hemispheres. The march spreads over one hemisphere and also spreads internally and via the corpus callosum to the opposite hemisphere, firing the opposite hemisphere. Then when it subsides, it subsides in the reverse order. The whole thing simply goes backward. When the scar and the adjacent cortical tissue are removed, those cases are followed on the operating table with the electroencephalogram, with multiple leads directly on the brain. Occasionally a curious thing happens; a migration of the epileptogenic focus occurs. With the patient on the table and this causative area taken out, theoretically, everything should be fine, but occasionally there will be a wandering of the epileptogenic focus, as much as 5 or 7 cm. in a half hour. There is no clear explanation for this. The other symptomatic epilepsies, such as toxic-infectious, I don't believe enter into this case.

I think that white count is a red herring, and the gram-negative diplococci, intracellular, are also noncontributory, although they are undoubtedly gonococci. They usually grow only on mucous or serous surfaces, unless they get into the blood stream and hit a heart valve. The patient did have an apical systolic murmur, but I think it was noncontributory. I do not believe this patient had a bacterial embolus to the brain. No evidence exists that she was an alcoholic or drug addict for toxic epilepsy, and I think we can ignore some of the tetanic things, the parathyroid adenomas, the hypoglycemias and the nephritic tetanies.

We can now progress to primary processes of the brain, especially brain tumors. The first tumor which can be ruled out immediately is the medulloblastoma, which is one of the most malignant tumors in the brain. That is a childhood tumor, occurring between the ages of five and ten, and is fairly frequent. The child will get up in the morning and complain of headache, vomit his breakfast, and then perhaps eat a second breakfast and keep this down. While posterior fossa tumors cause increased intracranial pressure, with headache and choked discs, it sometimes happens that a child will decompress himself by causing separation of the cranial sutures, in which event one gets a cracked-pot sound and the headache lessens temporarily. This type of tumor is extremely malignant, is a midline tumor in the center of the cerebellum, and although the neurosurgeon removes as much of the tumor as he can and radiates the remaining tumor afterwards, the child dies anyway.

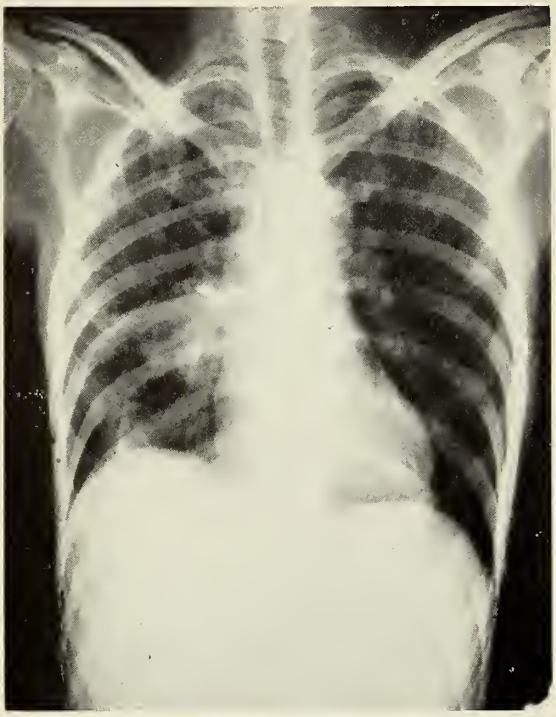
This present patient fits into the age group of another extremely malignant primary brain tumor, namely, glioblastoma multiforme, which is an extremely wild tumor and does not necessarily cause a pressure syndrome because it invades and destroys, rather than expands, without destroying the brain tissue. The peak age incidence for this tumor is between the ages of 35 and 45 and this patient was 47, so that she could well have had such a tumor. This tumor gives a syndrome of the white matter of the cerebral hemispheres, and from the time the first symptoms appear until death is usually only six months to a year. I have had two cases where the electroencephalogram pointed to a focal lesion although the neurological examination and spinal fluid tests were entirely normal. In each instance, a slow wave focus was shown by the electroencephalogram where the tumor had approached the surface of the brain. Ventriculograms showed the typical flattening out of the lateral ventricles, or so-called butterfly phenomenon, because some of these tumors arise in the corpus callosum and spread laterally to both hemispheres. Both patients were operated upon. The diagnosis was established and the patients died shortly thereafter.

I do not believe we need to be concerned with other brain tumors but would like to review briefly some of the more common ones. An astrocytoma would fit into the age group of this patient and this tumor occasionally causes convulsions. Another tumor primarily of neural tissue is the spongioblastoma, which is a benign tumor histologically but inaccessible neurosurgically, and it does not cause convulsions as a rule. A very common place for it is at the optic chiasm, and eye men have been embarrassed by taking out a piece of orbital tumor to find after the patient has died of hyperpyrexia that histologically the orbital tumor was an extension of spongioblastoma. Another very common site for this tumor is in the pons. However, this patient did not fit in that age group, which is much younger.

I do not believe that a pituitary adenoma need concern us here at all. A tumor not of neural origin is the so-called supracellar cyst or pharyngiocranioma, arising from the remnants of Rathke's pouch, and this tumor is usually easily diagnosed by its calcification and position. The meningiomas represent tumors of mesodermal origin and they, of course, cause convulsions when they are over the convexities of the hemispheres and around the motor area. Other tumors in the brain occur, of course, but are so rare that they can be ignored, I believe. These are the ependymomas, chordomas, primary melanoblastomas, pineal tumors, and the like.

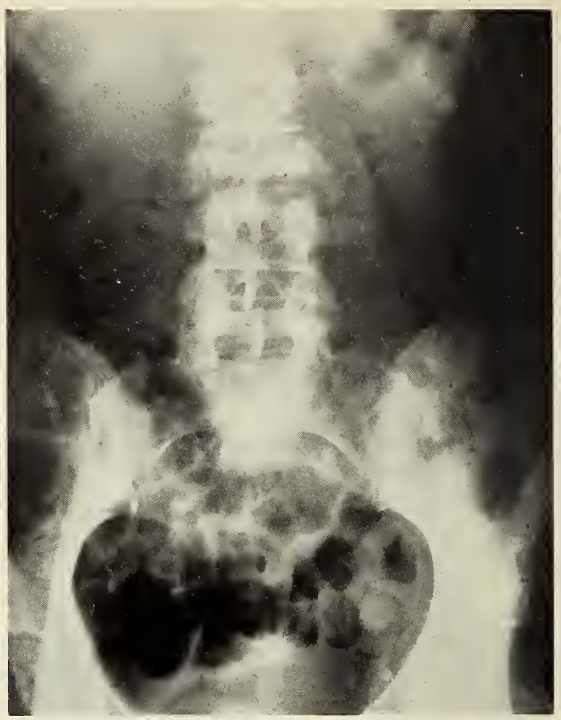
If one now considers metastatic tumors as a cause of epilepsy, we have a clue in that the patient had a hilar mass, and in spite of what one reads a convulsion may be the first overt manifestation of a bronchogenic adenocarcinoma. The figure which sticks in my mind is that 30 percent of bronchogenic adenocarcinomas will give as their first grand symptom one due to metastasis to the brain.[1] As you know, in the past neurosurgeons were embarrassed by operating upon patients who had a cough and a brain tumor and found that the

Figure 1



X-ray of chest: density adjacent to the right hilus.

Figure 2



X-ray of spine: collapse of lumbar III vertebra.

tumor which they discovered in the brain was a metastasis from a bronchogenic adenocarcinoma which at times does not even cause a cough. In some neurosurgical clinics, it is routine to take a chest plate of every patient with cough to rule out a bronchogenic carcinoma.

Neurologically, this patient showed a syndrome of the upper motor neuron. I am not sure whether one can depend upon the leg reflexes, however, because of the lumbar compression. It is true, however, that theoretically the spinal cord ends between the first and second lumbar vertebrae and this compression should cause a syndrome of the cauda equina and not of the cortical spinal tract.

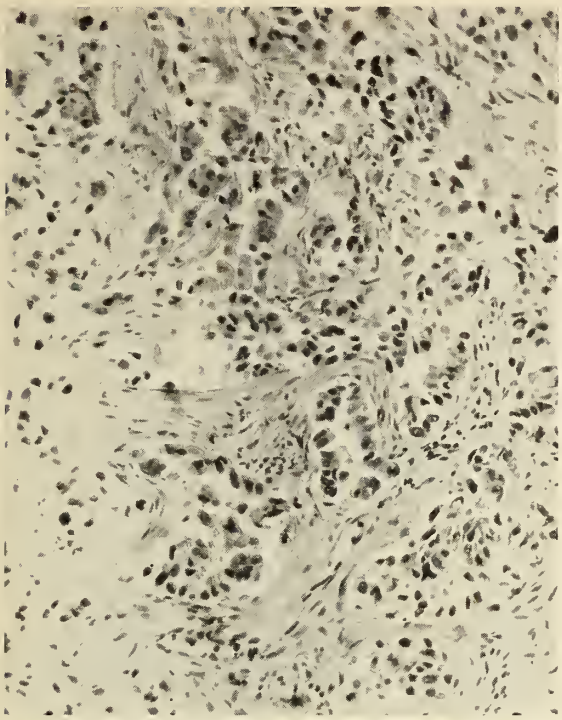
The neurological examination is not too helpful. The patient could have flexed her left leg and held it flexed because of pain in the left pelvis. However, if this is an actual neurological sign from above, then because of the crossed intervation of the corticospinal tract the lesion would be in the right hemisphere, subcortical I would say, in the region of the right internal capsule but approaching the surface of the right motor cortex. Since I assume the patient was right-handed, then the right hemisphere was the nondominant hemisphere and she should not have had aphasia, which apparently she did not. It is true that bronchogenic adenocarcinoma can also metastasize to the skull but the fact that there were no skull metastases does not rule out a metastasis to the brain substance itself. Her death was caused by exhaustion from these frequent tonic convulsions which put a terrific strain on the body, and she reached the point where the spark of life flickered and died from exhaustion.

In regard to the pigmentation spoken about, nothing is said about the pigmentation of the mucosa and I assume this is not an Addison's syndrome from involvement of the adrenal cortex. The blood pressure is normal. The spinal tap showed entirely normal findings as would be expected from a tumor lying away from the ventricles or subarachnoid spaces. I find this case extremely interesting because it illustrates an intracranial syndrome as the first symptom of a bronchogenic carcinoma (if I am correct in my diagnosis), and this is not a rare occurrence. That is, the patient did not have cough, did not have pain in the chest, and did not have a hemoptysis. The increased white count, the finding of gonococci, the pigmentation of the skin were, in my opinion, incidental and noncontributory to the primary disease which caused death. It is curious that with a destructive and metastasizing lesion, the sedimentation rate was normal. An increased white count and eosinophilia over 500 per mm. speak for malignant, necrotic destructive lesion.

(Blackboard diagrams and discussions of neural anatomy have been omitted.)

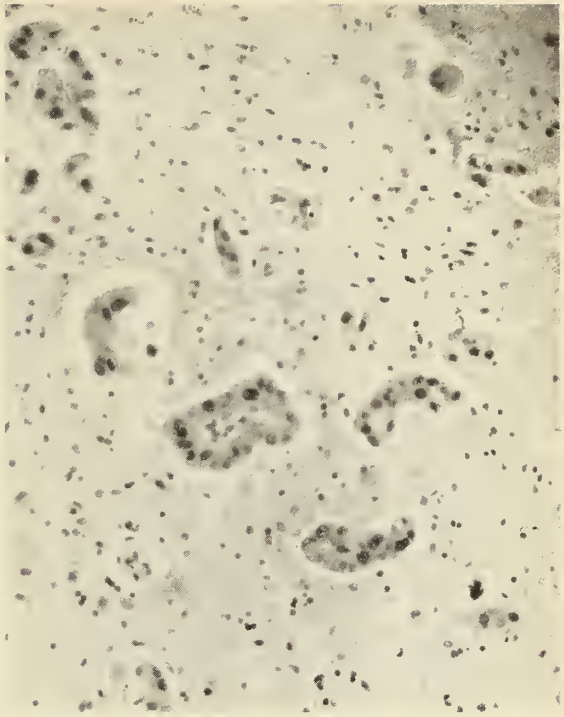
Diagnosis: Bronchogenic adenocarcinoma with obvious metastases to the right cerebral hemisphere and lumbar vertebrae.

Figure 3



Lung: note large hyperchromic and irregular malignant epithelial cells lining gland-like spaces. X 120.

Figure 4



Brain: note varying sized clusters of cells, some of which are forming gland-like structures. X 120.

Dr. Currie* (Roentgenologist) shows x-rays: The films of the chest are very interesting. It is not difficult to see that this nodular mass, which shows up very distinctly in the lateral view, is centrally located in the right hilar region. The destruction of the third lumbar vertebra is marked and there is no difficulty in seeing the lesion. The interesting part is the interpretation of these densities, in terms of the clinical picture. We reasoned from a radiographic standpoint similar to the way Doctor Buhrmester did in his discussion.

Doctor Duran (Resident in Pathology): Doctor Buhrmester covered this so completely that it doesn't leave very much for me to say. Only the positive findings will be emphasized. Examination of the abdomen disclosed the liver to be slightly enlarged and to contain multiple nodules, two of which were located at each lateral margin of the liver. These nodules were 4.0 cm. in diameter and were greyish yellow. Examination of the hepatoduodenal ligament disclosed the lymph nodes there to be markedly enlarged and upon cross section to be similar in appearance to that in the liver. The chest plate was removed and the pericardium examined and found to contain many small nodules less than 0.5 cm. in diameter. The pleura contained similar nodules. The lungs were removed and the right lung was examined first. It weighed 450 grams and the bronchial tree and blood vessels were opened and found to be not obstructed. The cross section of the lung revealed a nodule, grayish yellow, firm, located peripherally in the posteriolateral portion of the lower lobe. Except for involvment of the hilar node, the left lung was completely normal. Numerous small nodules were observed in the right diaphragm. Healed tubercles were observed in the spleen. Numerous small metastases were noted in the kidneys, and the adrenals were each involved, the right one being almost completely replaced by a metastatic nodule. The second, third, and fourth lumbar vertebrae were involved, with the third being almost completely collapsed. Examination of the brain revealed an irregular 4.0 to 6.0 cm. area in the right frontal lobe. The central area had undergone liquefaction, while the periphery was ragged and greyish yellow. This lesion extended for a depth of 4.0 cm. into the brain substance and was located near the middle gyrus. Therefore, in quick summary, we found a carcinoma of the lower lobe of the right lung with lymphangetic spread throughout the right lung, involving the hilar nodes on the right and left, with metastatic carcinoma to the pleura, pericardium, diaphragm, the kidneys bilaterally, the adrenals bilaterally, lumbar vertebrae 2, 3, and 4, and the right frontal lobe of the brain.

Doctor McFadden (Microscopic pathology): I want to comment very briefly, and commend Doctor Buhrmester on his excellent discussion of the case. In a nice sort of way, we have been waiting for

* R. W. Currie, M.D.—Roentgenologist, St. Elizabeth Hospital, Lafayette.

the chance to get even with him because we recently had him scheduled for one of these conferences and he called the day before to say that his schedule was mixed up and he would not be able to attend, so when we had a case of carcinoma of the lung that had never coughed, we thought we'd assign it to him. He did such an excellent job that we will have to try again sometime in the future.

We presented this case because it was a bronchogenic carcinoma which never coughed. The textbooks enumerate ten or twelve symptoms, and I believe cough is almost invariably listed as number one. Also, the patient was a woman and she was not old. We should, perhaps, be more aware of these lesions. Her clinical symptoms were referable to the central nervous system from the time she presented herself to the doctor until death, and it was only on routine x-ray studies that they found the lesion in the lung and the collapsed lumbar vertebrae. Bronchogenic carcinomata have been classified by Karsner[2] according to distribution in the lungs as follows: a) near hilum, b) diffuse infiltrative, c) peripheral and d) miliary carcinosis. The peripheral location of this particular tumor probably explains the fact that this patient did not cough. These tumors can again be classified microscopically. Slightly more than 50 percent of them are squamous cell in type. They may also be of the reserve-cell or small-cell type, the adenocarcinoma, the carcinoma simplex, or the so-called primary alveolar carcinoma. The nature of the primary alveolar type is somewhat uncertain and some workers are reluctant to accept this group as a particular type of bronchogenic carcinoma. It is to this group that we would like to assign this particular neoplasm. From one-third to one-half of the bronchogenic carcinomata metastasize to the brain. In this respect our case is a typical one. I should like to show two slides, one of the primary lesion in the lungs, and the other of the metastatic lesion in the brain. They are histologically similar.

Final Diagnosis: Bronchogenic carcinoma with generalized metastasis.

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INDIANA PUBLIC HEALTH ASSOCIATION PROGRAM

CHRONIC ILLNESS

April 17

Morning

Registration
Tour of new State Board of Health Building

Afternoon

Meeting at State Board of Health Building

1:30—2:00 Commission on Chronic Illness
Morton Levin, M.D., Chicago, Medical Director Commission on Chronic Illness

2:00—2:30 Report National Conference on Cardiovascular Disease
Reuben Behlmer, Head Health & Physical Education Dept., Arsenal Technical Schools, Indianapolis

2:30—3:00 Social Aspects of Problems of Clinically Ill
Mrs. Jane Morgan Johnson, Director Social Service Department, I. U. Medical Center

3:00—3:15 Recess

3:15– 3:45 Nursing Problems in Chronic Illness
Rachael Hill, R.N., Indianapolis, Inspection Section, State Dep't Public Welfare
Ruth M. Scott, R.N., Executive Director, Public Health Nursing Service, Fort Wayne

3:45—4:15 Chronic Illness in Hospitals
D. J. Caseley, M.D., Medical Director, I. U. Medical Center

6:30 Dinner, Lincoln Hotel
Speaker: Wilbur Shaw, President Indianapolis Motor Speedway

April 18

Morning

9:30—10:00 A Cancer Program
G. Howard Gowen, M.D., Chief, Division Cancer Control, State Department Public Health, Springfield, Illinois

10:00—10:30 A Coordinated State Program for Chronic Illness
Vlado A. Getting, M.D., Commissioner, Massachusetts Dep't of Public Health, Boston

10:30—11:00 Preventive Aspects of Chronic Illness
William F. King, M. D., Consultant in Gerontology, Indiana State Board of Health

11:00–12:00 Business Meeting

9:30—11:00 Environmental Sanitation
Panel Discussion on Relations Between State and Local Personnel
Moderator—Ralph Pickard, Director Environmental Sanitation, Evansville

Members of Panel:

T. E. Sullivan, Director Division of Food & Drugs, State Board of Health
William D. Shillinger, Sanitary Engineer, N.W. Branch, State Board of Health
George E. White, Director Milk and Food Sanitation, Evansville
Clarence E. Taylor, Sup't Community Sanitation, Public Health & Hospitals, City of Indianapolis

Afternoon

1:30 Health Officers' Meeting

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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Editor Emeritus: E. M. Shanklin, M.D., Hammond, Indiana

Editor: Frank B. Ramsey, M.D., 201 Hume Mansur Building, Indianapolis 4, Indiana
Associate Editor: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana
Managing Editor: Ray E. Smith, 1017 Hume Mansur Building, Indianapolis 4, Indiana
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THE PUBLIC IS BECOMING CANCER CONSCIOUS

THE Committee on Cancer of the Indiana State Medical Association recently reviewed the public education program of the Indiana Cancer Society. In spite of "cancerphobia" and some embarrassment at times, it was felt that the net result of the campaign was overwhelmingly to the good. The consensus was that many lives are being saved through awareness of cancer symptoms and willingness of patients to come to the doctor early. In fact, the committee has the impression that the public is learning more about cancer, *relatively*, than the medical profession is.

The Indiana Cancer Society and its parent, the American Cancer Society, through all types of information media have definitely made the "hush" word "cancer" a household topic of discussion. This achievement, if nothing more, has justified the existence of this semiprofessional organization. There are, however, many other accomplishments attributable to the organization and its program which make it an undeniable factor in more effective cancer control.

Public education is an unending process using many vehicles for transmission. It is difficult to measure the extent of knowledge gained by the general public, but it is safe to say from the results of recent polls that at least half of our population is aware of some of the danger signals of cancer. While very few are aware of all such signs, more and more are realizing the importance of early detection. The gradual adjusted decrease in death among women is proof of progress.

It is not necessary here to detail the program of newspaper articles, radio programs, movies, pamphlets, speeches and exhibits which make up a rounded public education program. It is probable that doctors are sometimes impressed with the volume of publicity which is released about a subject about which there is so little known.

Add to the newspaper and radio one and one-half million pamphlets, 500 showings of films, a like number of speeches, special bulletins, posters, essays and, not least, conversation, and you have an idea of the extent of public education about cancer in Indiana last year. In more formal approach must also be added "March Against Cancer," a biologic text for high school students written by Dr. Thurman B. Rice, which is now used in 550 high schools in the 92 counties of the state.

The cancer society is well aware of the dangers

of, as well as the necessity for public education. It cannot control all publicity on the disease and does not prepare all of it. An attempt, however, is made to keep it in bounds in so far as is possible.

With financial aid from the cancer society, the postgraduate faculty committee of Indiana University School of Medicine has been able to present for the past two years outstanding courses in malignant diseases, open to all Indiana physicians without charge. These courses have been without peer any place in the country. The third symposium is scheduled for April 12 and 13, and again the program brings leaders in the field to the medical center in Indianapolis.

Doctors are familiar with the manuals, films, slides, journals, exhibits and other media which are made available through the cancer society and the state board of health. The technicolor films "Early Diagnosis of Cancer," "Breast Cancer," and "What is Cancer?" (for nurses), are among the very finest of medical education films.

The cancer registry, located in the state board of health, has already collected more than 5,000 slides. Pathologists of the state have assembled on four different occasions in the past year to review these slides and followup on their accumulative information and consolidated opinion.

Personnel and equipment have been added to the research and teaching facilities of the medical school through efforts and financial aid of the cancer society. The most recent addition to the faculty is Dr. Edwin A. Lawrence, as oncologist, who will carry the title of Coordinator of Cancer Treatment and Research. The advancement of studies in cytology, radioactive isotopes, virus growth and genetics, and the procurement of extensive radiation equipment, and an electronic microscope, have all been expedited and greatly aided by financial help from the cancer society, plus funds raised by the Elks Lodges and Lions Clubs of Indiana. For this advancement of professional knowledge a total of $143,791 was invested at Indiana University and Purdue University last year. This does not include special projects financed by local county cancer units at Muncie, South Bend, Evansville, Lafayette and elsewhere. Plans for making additional programs available for district and county medical societies are under way.

COMMISSION ON CHRONIC ILLNESS[1]

FORMATION of the Commission on Chronic Illness in May 1949, by the cooperative effort of the American Hospital Association, the American Medical Association, the American Public Health Association, and the American Public Welfare Association, is one of the latest and most important milestones to mark the development of a widespread and at times uncoordinated movement toward the systematic solution of the problems of the chronically ill.

The fruitful activities over a period of many years of such organizations as the American Cancer Society, The American Heart Association and the National Foundation for Infantile Paralysis have emphasized the advantages of special endeavor for control of specific diseases, and have highlighted the necessity of a comprehensive study of all chronic diseases.

The problem of prevention and care of chronic illness has been studied by various cities and states since the 1920's and was recognized in the Social Security Act of 1935. It has also been the subject of legislation by several states, for example, Indiana in 1945.

It is estimated that one-sixth of the population is the subject of chronic illness, and that over one and one-half millions are chronic invalids.

It is evident that, as the old-age segment of the population increases, the problem will become greater. Increasingly successful medical efforts toward the prevention and control of communicable disease has focused more attention on the need for improvement in the prevention and care of degenerative diseases.

The gradual dissolution of many of the public institutions, such as poor houses, together with the fact that general hospitals are crowded with the acutely ill and are not suited for long-term cases, has placed a tremendous demand on nursing homes.

Work toward a solution on a national scale was initiated by the Joint Committee on Chronic Disease in 1946. This committee was formed by the same four organizations which last year organized the Commission. The present organization has inherited much data which resulted from spade work done by the committee and from the Interim Commission on Chronic Illness in 1948.

Objectives of the Commission have been announced as follows:

[1] The Commission on Chronic Illness, Origin, Structure, Objectives, Staffing and Financing. (Copies of this booklet may be obtained gratis by addressing the Commission at 535 N. Dearborn St., Chicago 10, Illinois. Copies of the "Proceedings of the First Meeting of the Commission" may be obtained at 20 cents each.)

1. To modify the attitude of society that chronic illness is hopeless.

2. To define the problems arising from chronic illness.

3. To coordinate separate programs for specific diseases.

4. To clarify the interrelationship of professional groups and agencies now working in the field.

5. To stimulate in every state and locality a well-rounded plan for the prevention and control of chronic disease and for the care and rehabilitation of the chronically ill.

The Commission is now organized under the chairmanship of Leonard W. Mayo, Vice-President, Western Reserve University. Morton L. Levin, M.D., is serving as director. Requests have been made for financial support from various foundations and voluntary health organizations. The American Medical Association has contributed $20,000 and has furnished office space and equipment.

CIVIL DEFENSE

AN ATOMIC explosion produces four main effects. Three of these are well known. One of the three has been grossly overrated and has received popular attention out of all proportion to its true casualty-producing ability.

The fourth effect has been discussed very slightly. It is now beginning to receive its proper amount of attention. It is probably the most important of the four, since from a practical point of view, it is the one effect which may be modified by educational methods.

I. The atomic bomb is, first of all, a tremendous blasting weapon. It produces a blasting effect similar to that of ordinary high explosives but of much greater intensity. It is capable of demolishing large areas of buildings, and produces casualties principally by propelling fragments against personnel.

II. Due to the intense heat produced, it is a highly efficient fire bomb, and will ignite most of the ruins which the blast creates. Due to the concurrent destruction of fire-fighting equipment and water pipes, the conflagration following an explosion is difficult to control.

III. The radioactivity released by the explosion has been the subject of much discussion. It is of minor importance, however, and is said to account for only 15 percent of casualties. It is probable that most of the personnel who receive lethal doses of radiation are also seriously endangered by the blast and fire effects.

IV. The panic which an atomic explosion causes is one of the principal casualty-producing effects. It was the panic and the lack of knowledge of what to do which resulted in many of the deaths in the bombing of Nagasaki and Hiroshima. Slightly wounded people were not rescued from the burning ruins; secondary blast injuries and burns were not adequately treated.

The characteristics and effects of atomic explosions have been studied extensively by the military services for the past four years.* The AMA Council on National Emergency Medical Service has taken the problem of civil defense as one of its most important assignments.

Planning at the national level has been initiated by the National Security Resources Board, which has recently issued a Civil Defense Planning Advisory Bulletin. This bulletin has been sent to the Governor of each state and territory, and local planning is now under way.

The medical profession is vitally interested in the planning, not only because the plan will contain many elements of a medical nature, but because the profession is admirably suited to assist in the education and indoctrination of the public. People are accustomed to look to their doctors for guidance in tight situations. One of the factors in civilian defense planning which will serve to prevent panic will be the knowledge that the medical services are organized and prepared.

A Britisher is quoted as saying that the best defense against the atomic bomb is not to be there when the explosion occurs. There is no doubt that this is true. However, as long as there is even a remote possibility that atomic weapons may be used in warfare, the next best defense, so far as the populace is concerned, is to educate the public, and to organize the relief services which would be necessary if such a disaster occurred.

That a large number of people can be psychologically prepared for possible catastrophe, and can be organized so that they may control widespread damage, was proved by the similar preparation of the population of London prior to the extensive bombing of that city during World War II.

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* Bulletins entitled "Medical Aspects of Atomic Weapons," and "Damage from Atomic Explosion and Design of Protective Structures," may be obtained from the Superintendent of Documents, U. S. Government Printing Office, Washington, D.C., at 10 cents per copy.

Editorial Notes

The Diabetes Committee reports that the diabetes detection program which was conducted during November 1949 proved to be eminently successful. To date 91,862 urine tests have been reported. Out of this number 475 new diabetics were discovered. All the county societies have not reported at the time this is written, and the final total will be larger. Plans are now being made for a detection campaign in November of this year. Some counties are conducting continuing programs, with a view to the more systematic and inclusive testing of the population, by year-round drives. This type of activity by the medical profession has proved to be good for public relations and should have the support of every physician.

The average length of life in the United States is still on the increase. According to figures released by the Public Health Service, the 1948 average length of life was 67.2. This is 0.4 years more than the 1947 average.

Physicians and others who are interested in the rehabilitation and gainful employment of handicapped and chronically ill persons will be interested in the following news release by the Veterans Administration:

A survey made in 1948 by the Labor Department's Bureau of Labor Statistics for VA matched the work performance of 11,000 impaired and 18,000 unimpaired workers in most major industries in this nation.

The survey disclosed that:

1. The handicapped suffered fewer serious accidents than the able-bodied (8.9 accidents per 1,000,000 man-hours worked, compared with 9.5 for the able-bodied).
2. The disabled experienced the same number of minor injuries as their able-bodied fellow workers (9.9 days per 10,000 man-hours worked for both groups).
3. Production records of the disabled were higher than records of the unimpaired (placing the output of the able-bodied at 100, the disabled workers' output was 101).
4. The disabled were absent from work a bit more frequently than the able-bodied (3.8 days lost per 100 work days for the disabled; 3.4 days lost for the able-bodied).
5. The voluntary quit rate of the handicapped was higher than the rate of the able-bodied (3.6 per 100 disabled workers, compared with 2.6 for the unimpaired).

Some details of the recent meeting of the Water Pollution Control Advisory Board in Cincinnati, Ohio, were made public recently by the Federal Security Administrator.

The board adopted in its entirety a proposal by Public Health Service officials to form a National Technical Task Committee on Industrial Waste.

The board was told the task committee would act as a coordinating agency for a number of major industrial groups composed of industries having allied interests. Each group will consist of representatives from individual industries.

The functions of the task committee will be in line with the board's previously announced stand that the solution of industrial waste problems is primarily the responsibility of industry. He added that the Public Health Service would assist the committee in the role of a clearing house for industrial waste problems.

The Cincinnati meeting was the third held since the board's formation in May, 1949, but it was the first time that body had met outside of Washington. The board was established under the Water Pollution Control Act of 1948 to review Public Health Service water pollution control activities and make recommendations to the Surgeon General.

The quality of dental care being provided the British public is deteriorating under the British National Health Service, *The Journal of the American Dental Association* declared editorially.

Quoting recent reports from the British Isles, *The Journal* said that the government program of providing free dental service to all citizens has extended dental services to large numbers of persons which they might otherwise have not received and had increased the practice of dentists, particularly in poorer neighborhoods.

"However," the editorial said, "these two assets are counterbalanced by many liabilities which already have lowered the standards of dental practice and threaten to lower still further standards of dental health." It continued:

"Dentists who accept all patients who present themselves for treatment work harder, longer hours and under greater nervous strain than formerly. Although their income has improved, their health has suffered. Harried and hurried, they are unable to render the quality of service which they formerly gave their regular patients. Under these circumstances patients become disgruntled, dentists become distracted and the good will of their practice deteriorates. Dentists who restrict the number of new patients in order to provide their old patients with high quality service have found their income seriously reduced."

President's Page

NOW IS THE TIME

MY DAUGHTER, who teaches commerce, mentioned one day that the standard practice drill for typing students is this sentence: "Now is the time for all good men to come to the aid of their party." It occurred to me that those words hold timely advice for all of us right now, for in the May primaries we will nominate candidates who will be elected to office in November to be our voices in the state and national legislative bodies. These candidates will have the power to vote us all into a welfare state; therefore, any candidate who, before the May election, will not commit himself to vote against socialization must not be nominated. Now is the time for YOU to come to the aid of your party. Secure those commitments, particularly in regard to socialized medicine, from all primary candidates, for some of them will become official nominees on your party ticket. Then, too, review the voting done by those already in office who are seeking renomination. If they favored socialization, now is the time to replace them.

Since last year at this time, socialized medicine in England has cost one billion dollars—25 percent more than the Labor Government's estimate, and although England took forty cents out of every dollar for taxes and kept its citizens living under a yoke of strict rationing, millions of American dollars—the American taxpayers' money—had to be used to keep the British welfare state functioning.

Socialization is on the way out in England. Now is the time to keep it out of our country by defeating all socialistic-minded candidates.

E. S. Black

Medical Panorama by the Associate Editor

How Is Your Blood Cholesterol?

Not many physicians, we wager, think of life insurance companies as colleagues in medical research, yet these organizations are in a position peculiarly suited to certain types of clinical research. Witness the numerous records they have of medical examinations, many showing minor defects or variations from "normal," and including of course the so-called "normal" itself, which they can follow to the ultimate conclusion that flesh is heir to:

> It must be apparent that life insurance has a very substantial interest in medical research and progress, for beyond the specific problems of insurance medicine, improvement in the health and longevity of the population is of vital concern to insurance. The need for fostering research has been recognized by the life insurance companies of the United States in the creation, in 1945, as a cooperative enterprise among the various companies, of the Life Insurance Medical Research Fund.

From such an enormous statistical storehouse one can draw conclusions which should have practical prognostic, and therefore therapeutic, value. *Minnesota Medicine* for January 1950 contains an article (quoted above) by Harry E. Ungerleider, M.D., Medical Director of the Equitable Life Assurance Society of the United States on "Life Insurance and Medical Research," which dwells at length on the considerable range of normal variation in cardiovascular examination and evaluation. It includes remarks on many angles of this problem, one of the most interesting and provocative of which is the following:

> Currently, we are actively engaged in studies on various aspects of arteriosclerosis. Some of you may be acquainted with our survey of arteriosclerosis which appeared in the *American Journal of Medicine* some months ago. In a study we recently carried out on the significance of blood cholesterol, it was found that significantly less arteriosclerosis occurred in the subjects with a low level of blood cholesterol compared to those with so-called normal levels of cholesterol and with hypercholesterolemia. These observations suggest that the so-called normal cholesterol is, in reality, a high cholesterol, and that the cholesterol level of the average American population is of such an order as to predispose to the development of arteriosclerosis. One of the difficulties in cholesterol studies has been obviated by the introduction by Kendall and his colleagues of a highly accurate method for determining its concentration in the serum, a technique we are now employing in our laboratory. The prevention of arteriosclerosis is beyond question the Number 1 public health problem in the United States today. It will be of immense importance to establish whether, as our preliminary studies suggest, low levels of blood cholesterol confer protection against the development of arteriosclerosis, and if this is so, to find simple and effective means to maintain a low level of blood cholesterol.

Of course, much water will have to run over the dam before prevention, or even postponement, of arteriosclerosis is accomplished, but so many of us are inclined to accept the inevitability of arterial degeneration without question that it is refreshing to learn of any progress in combating it, no matter how slight. A toe-hold is better than no hold.

Dedicated to the Taxpayer and His Remaining Dollars

A revision of the "Gettysburg Address"

One score and seventeen years ago, our fathers brought forth upon this nation a new tax, conceived in desperation and dedicated to the propotion that all men are fair game.

Now we are engaged in a great mass of calculations, testing whether that taxpayer or any taxpayer so confused and so impoverished can long endure.

We are met on Form 1040. We have come to dedicate a large portion of our income to a final resting place with those men who here spent their lives that they may spend our money.

It is altogether anguish and torture that we should do this. But in a legal sense we cannot evade—we cannot cheat—we cannot under-estimate this tax. The collectors, clever and sly, who computed here have gone beyond our poor power to add or subtract.

Our creditors will little note nor long remember what we pay here, but the bureau of internal revenue can never forget what we report here. It is for us, the taxpayers, rather to be devoted here to the tax return which the government thus far has so nobly spent.

It is rather for us to be here dedicated to the great task remaining before us—that from these vanishing dollars we take increased devotion to the few remaining; that we here highly resolve that next year will not find us in a higher income bracket; that this taxpayer, underpaid, shall figure out more deductions; and that taxation of the people, by the congress, for the government, shall not cause our solvency to perish.

—*Record-Tribune, Roundup, Montana.*

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

EWING AND THE DOCTORS

Oscar Ewing, the federal security administrator, who has been studying socialized medicine in Europe in the hope of putting it over in the United States, with himself as boss, announced that he plans to make some changes in the administration bill. These, he said, would revise the proposed system of compensating doctors brought into state service in order "to reduce the opportunities for collusion between patients and doctors to augment medical fees."

Mr. Ewing not only proposes to divest America's doctors of their property rights in their careers, developed through long years of training and application to their profession, but insults them by implying that they are chiselers and cheats. Only he and the New Dealers, he implies, are righteous and trustworthy.

While this mouthpiece for big government was sounding off in Switzerland, another branch of the administration he represents was compelled to acknowledge that the nation's health had made great strides under the practice of medicine by a free profession which Mr. Ewing affects to deplore. The office of vital statistics reported that the death rate in 1948 of 9.9 for each 1,000 population was the lowest of record for this country, comparing with 10.1 for 1947 and 10 for 1946.

Heart disease, accounting for 471,469 deaths in 1948, and cancer, which caused 197,042 deaths, were again the leading killers. During 1949, however, the medical profession had reason to hope that the conquest of cancer might not be too far in the future. One disease after another has yielded to the progress of medical science during the first half of this century, and there is no reason why a free profession, remaining free, cannot go on to similar achievements in the fight against the remaining ones.

Mr. Ewing has had no part in this, nor has anyone else in government. The men who improved the nation's health, who have defeated the great killing diseases, one by one, or limited their dread effects, and who have enabled Americans to live longer, are rewarded by Mr. Truman's hired man with the epithets of pickpocket and thief. They must be watched and policed by the government, he says, lest they steal the people's money.

To accomplish this, he would institute a bureaucracy which, if it conforms to the British system which Mr. Ewing so greatly admires, will cost the taxpayers more than a whole union of bandits could take at gunpoint in a year's time. Sir William Douglas, permanent secretary in the British health ministry, has been obliged to report that nearly one in every 100 persons in Britain works for the government health service. The total administering the British plan is 400,000, which Douglas himself concedes to be a "staggering figure."

Much the same thing, only on a greater scale, can be expected under political medicine here. It will become a great patronage scheme, loading hundreds of thousands more of New Dealers on the backs of the taxpayers. It isn't the doctors who are racketeers; it is Mr. Ewing and the whole New Deal crowd which is trying to whip up hate against the medical profession, but whose supposed philanthropy would prove to be merely a gigantic extension of spoils politics into an honored and distinguished field of private American endeavor.

—*Chicago Tribune*

WORDS THAT MUST NEVER DIE

An annual report is usually sterile of purely emotional eloquence. But deep down in the report of Secretary of Agriculture Brannan, released for publication yesterday, there appears an arresting passage. In it one finds pathos, if not tragedy; a philosophical acceptance of the inevitable, reminiscent of the true stoic. That passage should be lifted from its dull context, engraved in marble or other lasting stone and placed above the main portal of the Department of Agriculture's fine building. It reads:

"Experience with potatoes and with eggs shows that it is much easier to buy than to sell."

—*Washington (D. C.) Evening Star*

CANCER CONTROL—A COMMUNITY PROBLEM

ROLLIS S. WEESNER*

INDIANAPOLIS

WE ARE all familiar with the fact that the most intensive attack in the history of medicine is now being waged against the second greatest killer of man—cancer. The multi-million dollar research program throughout the nation, involving hundreds of institutions and individual scientists searching for the cause and a cure for the disease, is being watched with hopeful anticipation. Meanwhile the public is being educated to make use of the known methods of control and to become apprehensive of the symptoms of approaching cancer. The medical profession, through its own leadership and participation in the program, is increasing its success in better control by cooperation and intensive study while awaiting new weapons. The program of research, education and service is taking definite form.

CANCER CONTROL OBJECTIVES

The Indiana Cancer Society, Inc., with its 92 county units, a division of the American Cancer Society, is a voluntary health agency engaged in promoting the control of cancer through:

a. The maximum use of the methods already available for the prevention, diagnosis and treatment of cancer;

b. Enlightenment of the public to the known facts about the disease; and

c. Research for new methods of prevention, diagnosis and treatment.

In order to achieve maximum efficiency in the methods now available for the treatment of cancer, the following four cardinal objectives must be attained:

1. Early recognition of the signs and symptoms of cancer.
2. Early diagnosis.
3. Prompt treatment.
4. Adequate treatment.

These four objectives can be achieved best by means of an intensive educational program for both the laity and the medical profession. But education alone is not enough. Adequate facilities for diagnosis and treatment must also be made available to both the patient and the doctor.

The service program involves those activities of the society which deal directly with the cancer patient or the potential cancer patient. It is designed to promote the provision of adequate facilities both for the patient and the doctor in the fight against cancer.

SUPPLEMENTARY SERVICE ACTIVITIES

The service program involves not only the prevention, diagnosis and curative treatment of cancer, but additional activities as well, such as assistance to the cancer patient, when needed, palliative measures to relieve suffering, and care for the terminally ill. While the need for adequate care of the advanced cancer patient is apparent, it should be recognized that this is primarily a humanitarian effort rather than a direct attack on the problem of cancer. Preferably, emphasis should be placed on the type of program which will reduce the number of advanced cancer patients.

PURPOSE AND FUNCTION OF SERVICE PROGRAM

The voluntary health agency exists for the purpose of assisting the people to meet a health menace not controlled by existing organizations. Our function, like that of other health agencies, is to advance knowledge by pushing forward the frontiers of science and to apply this increased knowledge to the health problem.

The control of cancer requires research, education, and service to the cancer patient. All this involves the medical profession, the hospital, the public health service, nursing service and other groups. Obviously no one agency, governmental or private, has resources adequate to cope with a problem of this magnitude. The necessity for seeking assistance and cooperation of all groups is apparent.

The society may best serve the people by remaining a dynamic force so flexible that it may render assistance wherever the need is greatest, rather than to become static by assuming a permanent maintenance responsibility. Its most valued service may be to show the need, to point the way to better cancer control, and demonstrate the method by which this may be achieved. The health of the people is too important in our national economy to permit a great need to go unheeded or to depend entirely on voluntary contributions once it has been established that the need exists.

The ultimate goal of the voluntary health agency is to bring disease under control and so to put itself out of business by removing the reason for its existence.

It is therefore evident that the service activities in any community can only supplement existing institutions. Due to legal regulations and policies,

* Executive Director, Indiana Cancer Society, Inc.

however, this supplementation can be most welcome and many times of vital importance in meeting the problems of cancer patients.

AVAILABILITY OF FACILITIES

The implementation of the society's short range objective, and the saving of the greatest possible number of lives with the resources now at hand, calls for the availability of four types of facilities which are considered as basic to a complete cancer service. These are:

1. **The Information Service.** A source of public information concerning cancer and the cancer services available in the community. Permanent information offices staffed full time now operate in Hammond, East Chicago, Gary, South Bend, Elkhart, Fort Wayne, Anderson, Richmond, Indianapolis, Terre Haute and Evansville. Other centers, such as Vincennes, Lawrenceburg, Rensselaer, New Castle, Jeffersonville, and many other communities have definite information service programs manned by volunteers.

2. **The Detection of Cancer.** The physician's office or a center where apparently well persons may receive a general examination, the primary purpose of which is to disclose unsuspected cancer and precancerous lesions. This service should exist in every community. The American Cancer Society is now placing emphasis on "Every Doctor's Office A Detection Center."

3. **The Cancer Diagnostic Clinic.** A clinic where patients who present signs or symptoms suggesting cancer may go for certain diagnosis. The diagnostic center is equipped with proper diagnostic instruments and qualified medical personnel and may serve many communities. It is the consultation center for specialists and the family doctor and his patient. Diagnostic centers are now operating in Evansville, Terre Haute, Indianapolis (General Hospital and Medical Center), Anderson, Crawfordsville, Lafayette, Rensselaer, Bluffton, New Castle, Columbus, South Bend and Lake County. Fort Wayne has a detection clinic. More centers are needed.

4. **The Treatment of Cancer.** The center that can qualify for diagnostic services can usually also treat the disease. Treatment may be very adequate from the private sources for specialized medical treatment or we may have a full cancer clinic such as the one at the Medical Center, Indianapolis, where detection, diagnosis and treatment are available for the medically indigent from throughout the state.

These facilities are arranged or suggested in units so that even a small community may participate in the cancer control effort. In larger cities all four facilities may be present and function as one complete unit, while in small towns only an information service may be present. Again, any doctor's office can be a detection center and diagnostic clinics strategically set up can serve a number of communities while one centralized full cancer clinic may care for patients referred from many diagnostic clinics.

SUPPLEMENTARY SERVICES

Although the above facilities hold positions of top priority among the projects of the service program, they are by no means the limits of SERVICE, in its true meaning, which may be extended to the cancer patient. County cancer societies can provide additional services for taking care of the varied needs of the patient with cancer. Among these possibilities when needed are:

1. **Transportation Service.** Transportation of cancer patients to and from the place of treatment.

2. **Dressings.** Preparation and sterilization of surgical dressings needed by cancer patients.

3. **Loan Cupboards.** A source of equipment and appliances frequently needed by patients with cancer or those convalescing from treatment for cancer such as: bed pans, wheel chairs, crutches, colostomy bags, et cetera.

4. **Home Service.** Provision of nursing care and domestic or social assistance to the cancer patient and his family within limits.

5. **Comfort Kits.** Gift packages of simple toilet and bedroom articles for the indigent patient entering a hospital for the first time.

6. **Terminal Care.** Emergency care for patients with terminal cancer by the society at the local level until permanent public support is provided.

Nor are these all. Local needs and local initiative will suggest other ways to lighten the burden of the cancer patient. How far they go depends on funds, cooperation and vision.

Cancer is primarily a medical problem but it has many social implications and oftentimes is very expensive. The broad program of cancer control of the American Cancer Society calls for money on three levels: national, state and county. The division is on a 40-20-40 basis, meaning that 40 cents of each dollar goes to the national research and education program, 20 cents to the supporting research and education efforts on the state level, and 40 cents remaining in the county for service and community education.

Since the entire collection in a community are only pennies on a per capita basis, it is self-evident that the society cannot go into the problem of financial care of cancer victims. This is not the purpose, anyway, of the movement. It would be

duplicating the reason for existence of legal agencies such as the welfare department, the township trustee and private relief agencies. Cooperation and mutual interest and aid, of course, are necessary. Cancer is a gigantic problem that every American is interested in. The solving or control of this problem calls for teamwork from the medical profession, the hospitals, nursing profession, social workers, investigators, and on through the framework of human and scientific organization, and certainly from those agencies that exist for the purpose of administering to the human needs of mankind.

Your cancer society is a group of civic and service-minded volunteers who are your neighbors and want to help in the fight against this killer. They look to the medical profession for guidance and leadership. Seventy-nine of the ninety-two counties now have some type of service program. If cancer is to be fought on all fronts the local community and the local physician must do their part.

THE PHYSICALLY HANDICAPPED—A GREAT NATIONAL RESOURCE

Miss Mary Paxton*

Indianapolis

IT IS the purpose of the Indiana Society for Crippled Children and its affiliated county chapters to bring to each physically handicapped person in the state of Indiana the chance to become a useful, productive citizen.

The society is a private, nonprofit organization affiliated with the National Society. The POLICIES are that all kinds of service, leading to rehabilitation, is to be given to individuals with all kinds of crippling conditions, CAREFULLY AVOIDING THE DUPLICATION OF THE SERVICES OF THE OTHER PUBLIC AND PRIVATE AGENCIES. The DEFINITION of crippling condition is any condition which constitutes a vocational handicap. In addition to orthopedic cases it includes the epileptic, persons with speech, hearing and vision defects, as well as those with rheumatic fever.

In the past year the society gave service to persons representing 250 disabilities. This was accomplished through a broad, flexible service program as follows:

1. Early discovery.
2. Medical care and treatment.
   a. Wheelchairs, walkers and all kinds of artificial appliances.
   b. Physical therapy and occupational therapy.
3. Education.
   a. Pre-school centers.
      1. Centers for deaf children and centers for the cerebral palsied.
      2. Including various disabilities.
   b. Licensed teachers paid to tutor homebound children.
   c. The sponsoring of special classes for crippled children.
   d. Furnishing transportation to and within school if necessary.
   e. Speech and hearing therapy.
   f. Legislation extending public education to the crippled children.
4. Camping and recreation.
   a. Sponsoring teen-age and adult groups.
   b. Furnishing real camping to approximately 360 children each summer.
      Resident camping for from two to four weeks in four locations in Indiana.
      Day camping in three locations in Indiana.
      Trained personnel, including a registered nurse at each camp.
      Recreational programs for social adjustment.
5. Vocational training and remunerative employment, including the homebound.

All service provided by the Indiana Society for Crippled Children and its affiliated chapters is provided under the direction of the individual's family physician. Recommendations must come from the family physician on the purchase of any kind of equipment, educational program, recreational program and all other services.

The Medical Advisory Committee assists each county chapter in determining the needs of the community in order that the society may use its funds for cooperating with all other agencies in making needed service available in each county.

With approximately 200,000 physically handicapped children under the age of twenty-one in

* Director of Education, Indiana Society for Crippled Children—the Easter Seal Agency.

the state of Indiana, education has been an important phase of the society's service. The Indiana society inaugurated the homebound teaching program in Indiana with the state office paying licensed teachers for children in *unorganized counties*. The *forty-six organized counties* have their *own funds* and carry on their own service programs.

Rehabilitation centers will help in this vast job of rehabilitating the handicapped. The first rehabilitation center established by the society offers physical therapy, occupational therapy, kindergarten, recreational therapy and a sheltered workshop. Persons working in the sheltered workshop are those who cannot work at Goodwill Industries because of the severity of their handicaps. Subcontracts are obtained for them.

The majority of the county chapters carry on their service with volunteer persons, with local professional guidance. The state staff is kept small in order that the bulk of the funds raised by the society will be available for service to the physically handicapped.

The society raises its funds from an annual Easter Seal Sale. Ninety-one and seven-tenths percent of the funds raised remain in Indiana. Sixty percent remains in the organized county chapters. In the past five years the state office has granted to organized chapters more than $56,000 of its funds in order to help them with their service programs.

With all agencies working together, with the help of the physicians, the majority of the twenty-six million physically handicapped persons in the nation can become a great national resource.

ORGANIZATIONS THAT HAVE ADOPTED RESOLUTIONS OPPOSING COMPULSORY HEALTH INSURANCE

By County—March 8, 1950

INDIANA leads the nation by a wide margin in obtaining resolutions from organizations in opposition to compulsory health insurance. More than 700 resolutions protesting solialized medicine have been adopted by groups of all types and forwarded to Indiana's congressional delegations.

STATE-WIDE ORGANIZATIONS

Indiana Congress of the PTA
Indiana Bar Association
Indiana Veterinary Medical Association
Indiana State Florists' Association
Indiana Banker's Association
Indiana State Dental Association
Indiana Canners Association
Indiana Federation of Women's Clubs
Indiana Chamber of Commerce
Indiana Medical Association
Indiana Academy of General Practice
Roentgen Society
Indiana Woman's Auxiliary to Medical Assn.
Indiana Pharmaceutical Association
Indiana Public Health Association
Indiana V. F. W.
United Mexican Border Veterans
Indiana Department of the American Legion
Indiana Association of Podiatrists
Daughters of the American Revolution
Grand Voiture 40 & 8
Indiana Hairdressers and Cosmetologists Assn.
Indiana Farm Bureau, Inc.
Indiana Hospital Association
Indiana Implement Dealer's Association
Indiana Hearing Aid Dealer's Association of Kentucky and Indiana
Indiana Electric Association
Indiana Association of Accident and Health Underwriters
National Retail Hardware Dealer's Association
Indiana State Bottlers Association
Indiana Tuberculosis Association

DISTRICT ORGANIZATIONS

Ninth Councilor District State Medical Association
American Legion, Indiana Dept., Third District
Fifth Indiana Councilor District Medical Assn.
Seventh District Medical Society
District One, Indiana Federation of BPW
First District Dental Society
South Central District Dental Society
Eighth District Medical Society
Eleventh District, American Legion, Dept. of Indiana
Isaac Knapp District Dental Society
North Central Dental Society
Eleventh Councilor District State Medical Assn.
Fifth District, American Legion, Dept. of Indiana

ALLEN COUNTY

Fort Wayne Medical Society
Fort Wayne Woman's Club
Waynedah Legion Post No. 241, Fort Wayne
Pro-To Club, Fort Wayne
Chi-Lo-Sa, Fort Wayne
Tuesday Reading Club, Fort Wayne
Brotherhood Mutual Life Insurance Co., Fort Wayne
Pi Chapter Psi Iota Xi, Fort Wayne
Duodecima, Fort Wayne
Coterie Literary Club, Fort Wayne
Naomi Study Club, Fort Wayne
Wohela Club, Fort Wayne
V. F. W. No. 857, Jim Eby Post, Fort Wayne
Beta Nu Chapter, Pi Omicron National

BARTHOLOMEW COUNTY

Bartholomew-Brown County Medical Society
Columbus Chamber of Commerce
V. F. W., Columbus
American Legion Post No. 24, Columbus

BENTON COUNTY

Ambia Woman's Club, Ambia
Research Club, Boswell
Thursday Sorosis Club of Boswell

Women's Literary Club, Otterbein
Sphinx Club, Fowler
Fowler Woman's Club
Excelsior Club, Otterbein

BLACKFORD COUNTY

Research Club, Hartford City
Twentieth Century Club, Albany
Woman's Department Club, Hartford City
Universal Club, Hartford City

BOONE COUNTY

Tuesday Evening Club of Zionsville
Zionsville Woman's Club
Lebanon Chamber of Commerce
Lebanon BPW

CARROLL COUNTY

Junto Club of Delphi
American Legion Post, No. 222
Delphi Women's Club
Oracle Club, Delphi
Art and Garden Club, Flora

CASS COUNTY

Cass County Indiana Federated Clubs Council
Logansport Presbyterian Church Society

CLARK COUNTY

Clark County Medical Society
Charlestown Township Home Ec. Club, Charlestown
McCulloch Home Economics Club, Jeffersonville

CLAY COUNTY

Brazil BPW

CLINTON COUNTY

Arcadian Club of Frankfort
Fin-De-Seicle Circle, Frankfort
Peoples Life Insurance Co., Frankfort
Frankfort BPW

CRAWFORD COUNTY

Friendly Hour Club, Milltown
Fine Arts Club, English
Three Arts Club, Marengo

DAVIESS COUNTY

Atheneum Club of Elnora
Elnora Study Club
Mutual Improvement Circle, Odon

DEARBORN COUNTY

Moores Hill Women's Club, Moores Hill
Aurora Woman's Club
Review Club, Lawrenceburg

DECATUR COUNTY

American Legion, Post No. 129, Greensburg
Decatur County Medical Society

DEKALB COUNTY

Sigma Phi Gamma Sorority, Auburn
Alpha Pi Chapter of Kappa Kappa Kappa, Auburn
Registered Nurses Study Club, Auburn
American Legion Auxiliary, Auburn
Culture Club, Auburn
Entre Nous, Auburn
Ladies Literary, Auburn
Kenwigs, Auburn
Jeudi Society, Auburn
Auburn BPW
DeKalb County Medical Society
Jr. Entre Nous, Auburn
PTA of Auburn
Butler BPW
Twentieth Century Club, Garrett
Delphian Club, Garrett
Symposium, Ashley

DELAWARE COUNTY

Alpha Tau Jr. Women's Club, Muncie
Wednesday Afternoon Club, Eaton
Modern Priscilla Research Club, Muncie
Martha Washington Club, Muncie
Delaware County Federation Chorus, Muncie
Twentieth Century Club, Albany
Epsilon Kappa Tau Sorority, Muncie
Delta Beta Latreian, Muncie
Mayflower Club, Muncie
McRae Club, Muncie
Pegasus Poetry Club, Muncie
Riverside Culture Club, Muncie
Woman's Athenaeum, Muncie
Yorktown Jr. Woman's Club
Alpha Tau Jr. Club, Gaston
Woman's Club, Muncie
Pi Omicron, Muncie
Reticule, Albany
Wednesday Afternoon Club, Eaton
Woman's Club, Gaston
Altrusa Club, Muncie

DUBOIS COUNTY

Loyal Order Moose, Jasper
Jasper Rifle and Gun Club
Military Order Purple Heart, Jasper
Barber Shop Quartet, Jasper
St. Cecilia Study Club, Jasper
Village Homemakers—Crystal
Furniture & Veneer Workers, Jasper
DuBois County Navy Club, Jasper
Philharmonic Music Club, Jasper
Music & Art Coterie, Jasper
Victory Home Economics Club, Jasper
20th Century Literary, Jasper
Band Parents Club, Jasper
Liars Club, Jasper
Mothers Club, Jasper
BPW, Jasper
PTA, Ferdinand
St. Ann Society, Ireland
DuBois County Fair Association, Huntingburg
Tri Kappa, Jasper
Haysville Home Economics
Tee Totalers Club, Jasper
Order Eastern Star, Huntingburg
Girl Scouts, Huntingburg
Music Club, Huntingburg
V. F. W. Auxiliary, Huntingburg
War Dads, Huntingburg
American Legion, Huntingburg
Red Men, Huntingburg
Boy Scouts, Huntingburg
Daughters of Isabella, Huntingburg
D. A. R., Huntingburg
American Legion Auxiliary, Huntingburg
Daughters of Isabella, Ferdinand
American Legion, Ferdinand
American Legion, Auxiliary, Ferdinand
Boy Scouts, Ferdinand
St. Johns Ladies' Aid Society, Jasper
Jr. Music Club, Jasper
V. F. W., Jasper
Madelera Literary Club, Jasper
Little Theatre, Jasper
Kiwanis Club, Jasper
Young Men's Institute, Huntingburg
DuBois County Farm Bureau
Kiwanis Club, Huntingburg
V. F. W., Huntingburg
V. F. W., Jasper (Auxiliary)

ELKHART COUNTY

Elkhart County Medical Society
Lyceum Club, Nappanee
Bay View Club, Goshen
Woman's Club of Goshen
Current Club, Nappanee
American Legion Post No. 74, Elkhart
Elkhart's Womens Club
Culture Club, Elkhart
Thursday Club, Nappanee

Women's Club, Nappanee
Junior Women's Club, Nappanee

FAYETTE COUNTY

The Culture Club, Connersville
Cleo Club, Connersville
Fayette County Bar Association
Past President's Club, Connersville
Adelaide Proctor, Connersville
Sorosis Club, Glenwood
Woman's Club of Bentonville Community
E. S. O., Connersville

FLOYD COUNTY

V. F. W., Hobart Beach Post, No. 1693
New Albany's Woman's Club

FOUNTAIN COUNTY

Friday Study Club, Veedersburg
Booklovers Club, Covington
The Tri Arts Club, Attica
Secret Pal Club, Veedersburg
Kingman Woman's Club, Kingman
Friday Study Club, Veedersburg
Ma-Ma-Ru Club, Veedersburg
Pan Arts, Covington
Woman's Club, Covington

FULTON COUNTY

Akron Mother's Study Club
V. F. W., Akron, Post No. 9423
Rochester Woman's Club
Mt. Zion Club, Rochester
Burton Homemakers Club, Rochester
Child Study Club, Rochester
Philathea Class Church of Christ, Kewanna

GIBSON COUNTY

Oakland City BPW
Tri Kappa, Oakland City
Research Club, Oakland City
Kiwanis Club, Oakland City
Business Men's Organization, Oakland City
Community Club, Fort Branch
Gibson County Past President's Club, Fort Branch
Gibson General Hospital, Board of Trustees
American Legion, Johnson Curd Post No. 256, Oakland City
C. A. L. Club, Owensville

GRANT COUNTY

Marion Women's Department Club
New Century Federated Woman's Club, Van Buren
Current Opinion Club of Sweetser
Marion Women's Club

GREENE COUNTY

American Legion Post No. 196, Bloomfield
Tuesday Afternoon Club, Lyons
Alpha Delphian Club, Linton
Arion Club, Switz City
Beta Chapter E. S. O. 2nd District, Switz City
Linton BPW

HAMILTON COUNTY

Woman's Club of Westfield
American Legion, No. 45, Noblesville
Noblesville Woman's Literary

HANCOCK COUNTY

Maxwell Progressive Reading Club
Oak Leaf Club, Greenfield

HENRY COUNTY

Sesame Circle, Straughn
Tuesday Club, Springport
Tuesday Lucernian Club, Spiceland
Jr. Tuesday Lucernian Club, Spiceland
Henry County Medical Society
Sesame Circle, New Castle
New Castle Chamber of Commerce
Woman's Home Institute of Straughn
Henry County E. S. S., New Castle
Research Club, New Castle
Mt. Summit, Woman's Club
Lenba Club, New Castle
Past County President's Club, New Castle
New Castle BPW
Woman's Progressive, Mooreland

HOWARD COUNTY

Howard County Registered Nurses Club
Howard County Medical Society
Research Club of Greentown
American Legion Auxiliary Post No. 6, Kokomo
Chapter R. of P. E. O., Kokomo

HUNTINGTON COUNTY

Altrusa Club of Huntington
Women's Departmental Club of Huntington
Nineteenth Century Club, Huntington
Amaranth Club, Huntington
Huntington County Medical Society
Huntington Chamber of Commerce
Huntington County Bar Association
American Legion Post No. 160, Roanoke

JACKSON COUNTY

Study Club of Brownstown
Jackson County Medical Society

JASPER COUNTY

Remington Reading Club
Fortnightly Club, Remington

JAY COUNTY

Redkey Chamber of Commerce, Inc.

JEFFERSON COUNTY

Current Events Club, Madison
Jr. and Sr. PTA, Madison
Madison Woman's Club
Antioch Home Ec. Club

JENNINGS COUNTY

Contemporary Writer's Club, North Vernon
Current Books Club, North Vernon
Wednesday Research Club, North Vernon

JOHNSON COUNTY

Epsilon Sigma Alpha Sorority
American Legion, Carver-Wales Post No. 436
Johnson County Medical Society
American Legion, Franklin Post No. 205
Kiwanis Club, Franklin
Home Ec. Club No. 26, Whiteland
Woman's Club of Johnson County, Greenwood

KNOX COUNTY

Sandborn Woman's Club, Sandborn
Bruceville Study Club, Bruceville
Knox County Medical Society, Vincennes
American Legion Post No. 32, Bicknell
Semper Paratis Club, Bicknell
Progressive Woman's Club, Freelandville
Bicknell Women's Club, Bicknell
Westphalia Study Club
Progressive Arts Club of Sandborn
Edwardsport Golden Jubilee Club
Woman's Club of Bicknell
Booklover's Club, Oaktown

KOSCIUSKO COUNTY

Tuesday Dramatic Club, Warsaw
Twentieth Century Club, Warsaw
Leesburg Reading Club
Monday Club, Etna Green
Leesburg Literary
Mentone Reading Club
Columbia Reading Club, Milford
Mothers Study, Pierceton
New Century, Pierceton
Woman's Club, Sidney
Fine Arts, Silver Lake

Wednesday Afternoon Club, Syracuse
Round Table Club, Syracuse
Reading Club, Warsaw
Warsaw BPW

LAKE COUNTY

Chesterton BPW Club
PTA of Gary
V. F. W. No. 802, Hammond
Hobart Women's Club
LeRoy Fidelis Club
Whiting BPW
Lake County Medical Society
American Legion, East Chicago Post No. 93
Griffith Woman's Club
Crown Point Woman's Club
Lowell Woman's Club
LeRoy Woman's Club
Glen Park Jr. Federated Club of Gary
East Chicago Women's Club
Women's Federated Club of Lowell
Merrillville Women's Club
BPW of Crown Point
Indiana Harbor Women's Club
Cedar Lake Women's Club
Lowell Senior Women's Club
Lowell Junior Women's Club
Glen Park Women's Club, Gary
BPW of East Chicago
PTA of New Chicago
Royal Neighbors of Lake County, Griffith
PTA of St. Peter & Paul Church, Gary
Credit Women's Breakfast Club, Gary
Dunes Federated Women's Club, Gary
Hammond Women's Club
Glen Park PTA, Gary

LAGRANGE COUNTY

American Legion Post No. 215
The Philomaths, Howe
Tuesday Club, LaGrange
New Century Club, LaGrange

LAPORTE COUNTY

American Legion, John Franklin Miller Post No. 37
LaPorte County Medical Society
M. I. S. C., LaPorte
Westville Woman's Club
Amy Arndt Circle Presbyterian Church, Michigan City
American Legion Post No. 472, Hanna
Women's Study Club, Michigan City
Mothers of World War II, Unit 114, Michigan City
WBA Travel Club, Michigan City
Michigan City Hairdressers & Cosmetologists
Purdue Extension Club, Michigan City
Current Events Club, Hanna
Women's Benefit Association, Michigan City
Mayflower Club, Michigan City
Ladies of the Maccabees, No. 921, Michigan City
Coolsprings Woman's Club
Hi Tri Sorority, Michigan City
American Legion Post No. 21, Westville

LAWRENCE COUNTY

American Legion, Gillen Post No. 33
Woman's Department Club, Bedford

MADISON COUNTY

Madison Township Farm Bureau
V. F. W., Post No. 266
Madison County Medical Society
Elwood Chamber of Commerce
The Art Club, Anderson
Veteran Physicians of World War II of Madison County
Women's Club of Anderson
Richard Crashaw Club, Anderson
Woman's Auxiliary to Madison County Medical Society

MARION COUNTY

American Legion Post No. 186
Aftermath Club, Indianapolis
Chapter 20, Women's Organization National Retail Druggists Assn., Indianapolis
Service Study Club, Indianapolis
Social Study Club of Indianapolis
Thursday Lyceum Club, Indianapolis
Co-operative Club of Indianapolis
Delta Theta Tau Sorority, Inc., Alpha Epsilon Chapter
Ladies' Auxiliary No. 140, Hoosier City Branch, National Association of Letter Carriers
Disability Income Insurance Co., Indianapolis
College Life Insurance Co. of America, Indianapolis
Irvington Tuesday Club, Indianapolis
Indianapolis Real Estate Board
V. F. W., Benjamin Harrison Post No. 2985, Indianapolis
V. F. W., Post No. 1120, Indianapolis
American Legion Post No. 220, Indianapolis
Lions Club, Indianapolis
Atlas Mutual Life Insurance Co., Indianapolis
American Legion Post No. 374, Indianapolis
V. F. W., Post No. 1405, Indianapolis
American Legion, McIlvaine-Kothe Post No. 153, Indianapolis
American War Mothers, Marion County Chapter
Women's Department Club, Indianapolis
American Legion Post No. 276, Beech Grove
American Legion Post No. 300, Indianapolis
Mercator Club, Indianapolis
Minerva Club, Indianapolis
American Legion Post No. 334, Indianapolis
Jo-She-Ma Study Club, Acton
American Legion Post No. 208, Indianapolis
American Legion Post No. 38, Indianapolis
American Legion Post No. 107, Indianapolis
American Legion Post No. 116, Indianapolis
American Legion Post No. 264
40 West Business & Professional Men's Club, Indianapolis
Gyro Club of Indianapolis
Indianapolis Medical Society
Junior Chamber of Commerce, Indianapolis
Northeast Business Men's Association
Auxiliary of the Visiting Nurses Assn., Indianapolis
Aesculapian Society, Indianapolis
American Legion Post No. 4, Indianapolis
Health and Accident Club, Indianapolis
Present Day Club, Indianapolis
Inter Alia Club, Marion County
Cooperative Club of North Indianapolis
PTA, Potter Fresh Air School, Indianapolis
American Legion, Edgewood Post No. 448
Indianapolis Grand Voiture 40 & 8, 7th District
Quest Group, Indianapolis
Indianapolis Chamber of Commerce
Building Owners and Managers Association, Indianapolis
Alpha Zeta Latreian Group, Indianapolis
American Legion Post No. 26
Indianapolis Women's Auxiliary to the Railway Mail Assn.
Indianapolis Alumnae of Chi Omega Sorority
American Legion Post No. 397
American Legion Post No. 171
Children's Sunshine Club, Indianapolis
American Legion Post No. 134
American Legion Post No. 312
American Legion Post No. 34
American Legion Post No. 417

MARSHALL COUNTY

Argos Progress Club, Argos
Bourbon Reading Club, Marshall
American Legion, Bourbon Post No. 424
V. F. W., Bremen Post No. 8972
Argos Monday Club

Bremen Friendly Hour Home Ec. Club
Women's Saturday Club of Plymouth
BPW of Plymouth

MARTIN COUNTY

American Legion Post No. 120, Loogootee

MIAMI COUNTY

Tri Arts Club, Amboy
Buriett Study Club, Converse
Woman's Study Club of Denver

MONROE COUNTY

Tri U Club, Ellettsville
Bloomington BPW
Woman's Club, Bloomington
Nineteenth Century Club, Bloomington

MONTGOMERY COUNTY

Montgomery County Medical Society
Business & Professional Women's Club, Crawfordsville
Kiwanis Club, Crawfordsville
Pi Mu Research Club, Waynetown
New Richmand Tuesday Study Club, New Richmond
Ben Hur Life Association, Crawfordsville
The Art League, Crawfordsville
Linden Woman's Club
Ladoga Literary Circle

MORGAN COUNTY

Morgan County Medical Society
Martinsville Woman's Club
Mooresville Woman's Club
Federated Research Club, Mooresville

NEWTON COUNTY

Kentland Woman's Club.
Kentland Jr. Woman's Club
Ladies' Aid Society of Presbyterian Church, Kentland
Daynon Lodge No. 72 of K. P., Kentland
Woman's Society of Christian Service

NOBLE COUNTY

So-Sew Club, Kendallville
American Legion Auxiliary, Albion
Unorganized Women of Albion
Ligonier BPW Club
PTA at Kendallville
Noble County Medical Society
American Legion, Avilla Post No. 240
Kappa Kappa Kappa Associate, Kendallville
Kendallville Chamber of Commerce
Albion Study Club, Albion
Albion Progress Club
Sorosis Club, Albion
Bay View Reading Club, Kendallville
Tuesday Club, Kendallville
Sigma Eta Sorority, Kendallville
Rosary Society, Albion
Albion American Legion Auxiliary
American Legion Auxiliary, Kendallville
Literary & Historical Club, Albion
Ligonier Study Club
Culture Club of Kendallville
The Amicus Club, Kendallville
Gamma Xi of Tri Kappa, Kendallville
Delphian Club, Kendallville
Study Club, Kendallville
BPW Club, Kendallville
Angling Road Country Club, Kendallville
Postal Auxiliary, Kendallville
Quest Club, Kendallville

OHIO COUNTY

Rising Sun Woman's Club
Jr. Woman's Club, Rising Sun
BPW of Rising Sun
20th Century Club, Hartford

ORANGE COUNTY

Paoli Women's Club
Thursday Research Club, West Baden
American Legion Post No. 63, Paoli

OWEN COUNTY

B. H. Club, Patricksburg
Owen County Reading Club, Spencer
Fidelis Club, Spencer
Thursday Study Club, Spencer
Fortnightly Club, Gosport

PARKE COUNTY

American Legion Post No. 48
Current Literature Club, Rockville
Rockville Woman's Club
Greene Township Women's Club, Judson
Woman's Civic Club, Bloomingdale

PERRY COUNTY

Perry County Unit of American Legion Auxiliary, Tell City
Tell City V. F. W. Auxiliary
War Dads & Auxiliary, Tell City
Tell City Home Ec. Club
American Legion Auxiliary, Cannelton
Ladies' Adult Bible Class, Tell City (Evangelical Church)
Lafayette Spring Chapter D. A. R., Tell City
Home Mutual Fire Insurance Co., Tell City
Mt. Pleasant Home Economics

PORTER COUNTY

Porter County Medical Society
American Legion Post No. 94
Valparaiso Jr. Woman's Club
Chesterton BPW

POSEY COUNTY

Community Club, Cynthiana
Coteria Club, Mt. Vernon
Woman's Library, New Harmony
Homemakers, Poseyville
Fortnightly, Poseyville
Tercera, Poseyville
Vigenti, Wadesville
Tuesday Literary Club, Mount Vernon

PULASKI COUNTY

Beta Beta Latreian Club, Winamac
Garden Club, Winamac
Woman's Club, Winamac
Mother's Club, Winamac
BPW of Winamac
Tri Chi, Winamac

PUTNAM COUNTY

Woman's Club of Greencastle
Study Club of Bainbridge
Greencastle BPW
V. F. W. No. 3284, Roachdale

RANDOLPH COUNTY

American Legion, Randolph Post No. 39
V. F. W., Winchester No. 1633
West River Township Farm Bureau, Winchester
Winchester BPW

RUSH COUNTY

V. F. W., Jackson-Cox Post No. 1541
Rushville Group of Alpha Chapter of Epsilon Sigma Omicron
Thesis Club of Jackson Township, Rushville
Priscilla Art and Literary Club, Falmouth
Woman's Literary Circle of Carthage
Rushville BPW

ST. JOSEPH COUNTY

BPW of Mishawaka
South Bend-Mishawaka Board of Realtors
Izaak Walton League, St. Joseph County Chapter
St. Joseph County Medical Society
American Legion, South Bend Post No. 50
Association of Commerce, South Bend
North Liberty Woman's Club
Walkerton Jr. Woman's Club
Center Twp. Woman Club, South Bend

Mishawaka Woman's Club
Progress Club, South Bend
Roseland Woman's Club
Sigma Chapter, New Carlisle
Sumption Prairie Woman's Club, North Liberty
Thursday Club, South Bend
Walkerton Woman's Club
Clay-Harris, Granger
Riley Woman's Club, Lakeville
Portage Home Economics
Crumstown Home Economics, South Bend
Delta Beta Phi, New Carlisle
Mount Pleasant Home Economics, South Bend
Lydick Woman's Club
Carlisle Clover Club, New Carlisle
Mishawaka Jr. Woman's Club
Progress Jr. Woman's Club, South Bend
Auxiliary to the St. Joseph County Medical Society
George V. Rawson, Woman's Relief Corps No. 166, Auxiliary to G. A. R., South Bend

SCOTT COUNTY

American Legion Post No. 234
American Legion Post No. 358, Austin

SHELBY COUNTY

Mu Beta Club, Morristown
Aftermath Club, Morristown
Nora Klicks Club, Morristown
Coterie Club of Shelbyville
Sigma Lambda Chi, Shelbyville
Say Go Club, Morristown
Jr. Coterie of Shelbyville
Jr. Women's Club, Shelbyville
Fountaintown Tuesday Club
Pollyanna, Morristown
Branch of Alpha Chapter E. S. O., Fountaintown
Shelbyville Current Topics
Woman's Club, Shelbyville
American Legion Post No. 70, Shelbyville

STARKE COUNTY

American Legion Post No. 131

STEUBEN COUNTY

American Legion Post No. 257, Fremont
American Legion Post No. 423, Orland

SULLIVAN COUNTY

Crayville Farm Bureau

SWITZERLAND COUNTY

Eggleston Club, Vevay

TIPPECANOE COUNTY

Tippecanoe County Medical Society

TIPTON COUNTY

Tipton County Tuberculosis Association
American Legion Post No. 46
Tipton County Chamber of Commerce
Tipton Art Association
Tipton Kiwanis Club
Tipton Rotary Club
Tipton Lions Club
Kappa Kappa Kappa, Tipton
American Legion Auxiliary, Tipton

UNION COUNTY

American Legion Post No. 122, Liberty

VANDERBURGH COUNTY

Protestant Deaconess Hospital, Evansville
Evansville Area Hospital, Evansville
Welborn Memorial Baptist Hospital
Vanderburgh County Medical Society, Woman's Auxiliary
Vanderburgh County Medical Society
American Legion Post No. 8
Evansville Chamber of Commerce
Evansville Milk Distributors Association, Inc.
Northside Business Men's Assn. of Evansville
Amalgamated Assn. of Street, Electric R. R. and Motor Coach Employees of America, Local Div. 873, Evansville
Federated Liberal Arts Club, Evansville
Atheneum Club of Evansville
Southwestern Pharmaceutical Assn.
Vanderburgh County Tuberculosis Assn.
Evansville Assn. of Life Underwriters

VERMILLION COUNTY

Current Event & Art Club, Clinton
Delphian Society, Newport
Social Study Club, Cayuga
As You Like It Club, Dana
American Legion Post No. 184, Newport
American Legion Post No. 263, Cayuga

VIGO COUNTY

American Legion Post No. 481, Terre Haute
Terre Haute Bar Association
Vigo County Medical Society
Business & Professional Women's Club, Terre Haute
Terre Haute Federated Clubs
Arenie Club, Terre Haute
V. F. W. No. 972, Terre Haute

WABASH COUNTY

American Legion Post No. 15
Wabash County Medical Society
American Legion Post No. 402, Laketon
BPW of Wabash

WARREN COUNTY

American Legion Post No. 259, Williamsport

WARRICK COUNTY

Warrick County Medical Society
Literary Club, Boonville
Woman's Club, Boonville
Woman's Forum, Boonville
History Club, Newburgh
Study Club, Newburgh
Round Table Club, Newburgh
Past President's Club, Newburgh

WASHINGTON COUNTY

Woman's Study Club of Salem

WAYNE COUNTY

American Legion Post No. 65
Woman's History Club, Hagerstown
Hagerstown Progressive Club
American Legion Post No. 338
American Legion Post No. 442
Milton Cory Club, Milton
Current Events Club, Richmond
Helen Hunt Club, Cambridge City
World Life and Accident Association, Richmond

WELLS COUNTY

Wells County Bar Association, Bluffton
Bluffton Chamber of Commerce
American Legion Post No. 111
Foltz Club, Bluffton
Bay View Reading Club, Bluffton
Wells County Medical Society
Auxiliary to Wells County Medical Society
Bluffton Lions Club
Executive Board of Women's Guild, Bluffton
Wells County Tuberculosis Assn.

WHITE COUNTY

Monon Current Literature Club
American Legion Post No. 294

WHITLEY COUNTY

Commercial Development Club, Columbia City
Parliamentary Law & Literary Club, Columbia City
Kiwanis Club, Columbia City
Epsilon Sigma Omicron, South Whitley
Literary Club, South Whitley
Pi Beta Club, South Whitley

THE CARE OF HAND INJURIES*

Surface Injuries

I. The first-aid care of wounds of the hand is directed fundamentally at protection. It should provide protection from infection, from added injury, and from future disability and deformity. The best first-aid management consists in the application of a sterile protective dressing, a firm compression bandage and immobilization by splinting in the position of function (wrist hyperextended in cock-up position; fingers in mid-flexion and separated; thumb abducted and in mid-flexion, with tip pointing toward little finger). No attempt should be made to examine, cleanse, or treat the wound until operating room facilities are available.

II. Early definitive care requires thorough evaluation of the injury with respect to its cause, time of occurrence, status as regards infection, nature of first-aid treatment and appraisal of structural damage. For undertaking the definitive treatment the conditions required are a well-equipped operating room, good lighting, adequate instruments, sufficient assistance, complete anesthesia and a bloodless field. The treatment itself consists of aseptic cleansing of the wound, removal of devitalized tissue and foreign material (exercising strict conservation of all viable tissue), complete hemostasis, and the repair of injured structures, to be followed by protective dressing to maintain the optimum position. After-treatment consists of protection, rest and elevation during healing, and early restoration of function by directed active motion.

Burns, abrasions and avulsions may cause destruction and denudation of any area of the skin of the hand. The care of such injuries has three major objectives:

1. Protection from infection.
2. Early restoration of skin covering.
3. Avoidance of disabling scarring and contractures.

These objectives are sought in the various stages of treatment.

1. First-aid treatment.
   (a) Chemical burns.
   Remove chemical by profuse irrigation with water, preferably warm.
   (b) Heat burns, abrasions and chemical burns (after washing away the injuring agent).
   Apply sterile dressing completely to cover the hand and bandage firmly.

2. Definitive treatment.

   This should be carried on in operating room under conditions of strict asepsis. (Draping of field, sterile gloves, masking of operator and attendants.)
   (a) Gentle removal of first-aid dressing, soaking loose with normal saline solution if necessary.
   (b) Gentle cleansing of injured surface by light sponging with saline on cotton balls. If surface is dirty or greasy, it may be gently cleansed with sterile neutral soap in sterile water or bland detergent. Loose fragments and tags of skin are removed. Blisters are not opened.
   (c) Sterile strips of fine-mesh vaseline-impregnated gauze are smoothly applied to the injured surface. These are covered with dry sterile gauze, gauze being placed between adjacent fingers. The whole hand is covered with a thick layer of sterile mechanic's waste or fluff gauze, and splinted in the position of function. Elastic knit bandage is applied over all, including all fingers, with firm even pressure. The hand is kept elevated.

3. Subsequent dressings.

   The original dressing is left undisturbed for 12 to 14 days unless elevation of temperature suggests active infection requiring inspection. The second, and all subsequent dressings until healing, are done under completely aseptic conditions (as described above). Preparations for skin grafting should be made in advance.
   (a) The dressing is removed. Slough and debris are washed away by irrigation with normal saline solution (no scrubbing of surface).
   (b) Granulating areas from which slough has separated should be covered with thin split-thickness skin grafts.
   (c) Dressing, similar to that employed at first definitive treatment, is applied. Hand is splinted in position of function.
   (d) Further dressings, similarly conducted, are done at intervals of seven days until epithelization of burned surface is complete. Skin coverage by grafting should be secured as rapidly as possible, as the best assurance against infection, inflammation, infiltration, scarring and contractures. This early coverage by "skin dressing" is of the greatest importance, even when epithelization from the margins is proceeding satisfactorily. Split-thickness grafts are best for this purpose, even though it is anticipated that some of grafted area must later be removed for replacement by more suitable skin.

4. Restoration of function.

   As soon as epithelization of burned surfaces is complete, directed active use and exercise of the hand is begun. Normal use of the hand is encouraged and voluntary exercise and appropriate occupational therapy prescribed.

Committee on Industrial Health
Indiana State Medical Association

* Third of a series, prepared by the American Society for Surgery of the Hand, and released by the American College of Surgeons.

THIRD ANNUAL POSTGRADUATE COURSE ON MALIGNANT DISEASES

PRESENTED BY INDIANA UNIVERSITY SCHOOL OF MEDICINE
AND
INDIANA CANCER SOCIETY, INC.

April 12 and 13

Indiana University Auditorium

WEDNESDAY, APRIL 12

Morning Session

(Joint Program for Physicians and Dentists)
Medical School Auditorium

9:00 a.m.—Registration

9:30 a.m.—Introductory Remarks

Dean John D. VanNuys, School of Medicine

Dean Maynard K. Hine, School of Dentistry

Rollis S. Weesner, Indiana Cancer Society

10:00 a.m.—"Differential Diagnosis of Oral Lesions"
Danely Slaughter, M.D., University of Illinois

11:00 a.m.—"Malignancies of the Skin and Mucous Membrane"
Eugene Trabue, M.D., New York Medical College

12:00 noon—Film: "Breast Cancer—The Problem of Early Diagnosis," courtesy of the National Cancer Institute and the American Cancer Society

12:30 p.m.—Luncheon: Riley Hospital Cafeteria

Afternoon Session

DENTAL PROGRAM

Dentists Meet at School of Dentistry

1:30 p.m.—"Oral Tumors"
Danely Slaughter, M.D., University of Illinois

2:00 p.m.—"Differential Diagnosis of Oral Lesions"
H. B. G. Robinson, D.D.S., Ohio State University

2:30 p.m.—Presentation of Tumor Cases by Staffs of Indianapolis General, Cold Springs VA, and I. U. Medical Center hospitals

4:00 p.m.—Return to Medical School Auditorium for Roundtable Discussion

Afternoon Session

MEDICAL PROGRAM

Physicians Meet in Medical School Auditorium

2:00 p.m.—"Development of Cancer Research"
G. Burroughs Mider, M.D., University of Rochester

3:00 p.m.—"Management of Cancer of the Rectum"
R. K. Gilchrist, M.D., University of Illinois

4:00 p.m.—Roundtable, the Speakers Participating

Wednesday Evening

Medical School Auditorium

8:00 p.m.—"The Diagnosis of Cancer"
Samuel C. Harvey, M.D., Yale University

THURSDAY, APRIL 13

Morning Session

Medical School Auditorium

10:00 a.m.—"Roentgen Diagnosis of Malignant Tumors in Children"
Edw. B. D. Neuhauser, M.D., Harvard University

11:00 a.m.—"Neoplasms of the Adult Kidney"
N. G. Alcock, M.D., University of Iowa

12:00 noon—Repeat Showing of film on Breast Cancer

12:30 p.m.—Luncheon: Riley Hospital Cafeteria

Afternoon Session

Medical School Auditorium

2:00 p.m.—"Modern Concepts in the Treatment of Leukemia and Allied Diseases"
G. E. Cartwright, M.D., University of Utah

3:00 p.m.—"Estimation of Preoperative Risk and Postoperative Care of the Cancer Patient"
John LaDue, M.D., Cornell University

4:00 p.m.—Roundtable, the Speakers Participating

News Notes

INDIANA ACADEMY OF GENERAL PRACTICE ANNUAL MEETING—APRIL 19

The annual meeting of the Indiana Academy of General Practice will be held at Indiana University School of Medicine, Wednesday, April 19. The program will be as follows:

9:00 to 9:50 A.M.—Liver Clinic, Dr. Bernard Rosenak.

10:00 to 10:50 A.M.—Pediatric Clinic, Dr. Mathew Winters.

11:00 to 11:50 A.M.—Hypertension Clinic, Dr. J. O. Ritchey.

12:00 NOON—Luncheon in medical school cafeteria.

1:00 P.M.—Address of welcome by Dr. Lester Bibler; business meeting, with reports from the Board of Directors and the committees. Contemplated changes in the by-laws will be presented. Election of officers will be held, and delegates will report on the recent national assembly in St. Louis.

2:00 P.M.—Address of welcome by Dr. John D. VanNuys, dean of Indiana University School of Medicine.

2:10 P.M.—"What Can Psychiatry Do for General Practice?" by Dr. Earl W. Mericle. This will be followed by a panel discussion, with Dr. Harry L. Foreman as moderator.

3:10 P.M.—Address by Mr. Ed Dowling, "A Fool There Was." To be discussed by Dr. Karl Ruddell.

4:10 P.M.—Paper on immunizations, "What's New and What's Old?" by Dr. C. E. Roach, of Eli Lilly and Company.

4:40 P.M.—Discussion and adjournment.

6:30 P.M.—Dinner, Indianapolis Athletic Club. (Wives invited.) Dr. James Denny, president of the Indianapolis Medical Society, will open the meeting, and then turn it over to Dr. Lester Bibler, who will present the gavel to Dr. Maurice Kahler, incoming president of the Indiana Academy. Doctor Kahler will present a certificate to Doctor Bibler, as outgoing president.
(The evening meeting will be held in conjunction with the Indianapolis Medical Society.)

8:00 P.M.—Address by Dr. Philip Thorek, of Chicago, on "The Acute Abdomen."

(Price of dinner $5.00 per plate. Send reservations in advance to Dr. Loren Martin, 2626 W. Washington Street, Indianapolis, or to Dr. Norman Booher, 447 East 38th Street, Indianapolis.)

BRAYTON CLINIC—MAY 9

The special clinic of the Alembert Winthrop Brayton Skin and Cancer Foundation will be held at Indianapolis General Hospital on May 9, and will be conducted by Paul O'Leary, M.D., from the department of dermato-syphilology at the Mayo Clinic. From 8:30 A.M. until noon there will be a discussion of problems in syphilis, and a viewing and discussion of cases, followed by a luncheon. At 8:00 P.M. the annual Brayton lecture will be given before the Indianapolis Medical Society. This will be a discussion of nodular and ulcerative lesions of the lower extremities.

The American Academy of Neurology will hold its first interim meeting in Cinncinnati, on April 14 and 15. It is being held in conjunction with the **American Chapter of the International League Against Epilepsy.**

The **American Association of Industrial Physicians and Surgeons** will hold its thirty-fifth annual meeting at the Hotel Sherman, in Chicago, April 24 to 29. The following participating allied groups will also meet at that time: American Conference of Governmental Industrial Hygienists; American Industrial Hygiene Association, American Association of Industrial Dentists; American Association of Industrial Nurses, Inc.

STATE NUTRITION MEETING

The Indiana Dietetic Association and the Indiana State Nutrition Council are planning a joint nuitrition program as a part of the spring meeting of the Indiana Dietetic Association on Friday, April 28, at Indianapolis.

Mrs. Julia Kiene, Director, Home Economics Institute, Westinghouse Corporation, will report on findings and results of a year's work in nutrition with a group of families.

Dr. Russell M. Wilder, the dinner speaker, is Professor and Chief, Department of Medicine, Mayo Foundation, Rochester, Minnesota. He has been a national leader in nutrition research for a number of years. He is the present chairman of the National Food and Nutrition Committee of the National Research Council. Doctor Wilder will discuss some of the newer aspects of nutrition.

The afternoon meeting will be at 3:00 P.M. in the Rainbow Room of the Severin Hotel, and the dinner and evening meeting will be in the Ball Room of the Marott Hotel.

Dr. John M. Paris, of New Albany, received a key for distinguished service from the New Albany Junior Chamber of Commerce at its meeting in January. The award was presented in view of "the many years of work Doctor Paris spent to make a Floyd County hospital a reality; his active part in work of the Citizens Health Committee; as a member of the City Council; his proposal of a restaurant ordinance; and his service as examining physician for the Boy Scouts."

At the recent convention of the Memphis Eye, Ear, Nose and Throat Society, **Dr. Kenneth L. Craft**, of Indianapolis, presented a paper on "Nasal Allergy."

Dr. Maurice D. FitzGerald has moved to Evansville, where he will practice radiology. A 1937 graduate of Loyola University School of Medicine, Chicago, he spent three years in general practice in Chicago, before entering the Army. Doctor FitzGerald spent five years in service with an evacuation hospital of the Sixth Army. He has had special radiological training at Mercy Hospital, Chicago, and at the Schmitz Institute of Radiation Therapy.

A native of Wisconsin, **Dr. George Godersky** has opened an office for the practice of obstetrics and gynecology at 512 Odd Fellows Building, in South Bend. He is a 1942 graduate of Indiana University School of Medicine, and spent three years in the Army. For the past three years he has been a resident at the Indiana University Medical Center.

Announcement has been made by **Dr. John Housley** that he will maintain offices both in Churubusco and Huntertown. He has been living in Churubusco, but recently moved to Huntertown.

Announcement has been made by **Dr. Harland V. Hippensteel** of his opening of an office with **Dr. Bonnell M. Souder** at Auburn. Doctor Hippensteel is a 1946 graduate of Indiana University School of Medicine, and was recently separated from the Navy.

Dr. Ward Laramore has opened an office in LaPorte, where he is limiting his practice to cardiology and internal medicine. He is a graduate of Indiana University School of Medicine, a veteran of World War II, and has had five years of training in his specialty.

A native of Wabash, **Dr. Richard S. Logan** has opened an office in Wabash, where he will specialize in pediatrics. After graduating from Indiana University School of Medicine in 1943, Doctor Logan interned at Gorgas Hospital in the Panama Canal Zone, then served in the Army. He was separated from service in August, 1946, and since then has been taking special training in pediatrics.

Dr. C. O. McCormick, Sr., of Indianapolis, recently addressed the Owensboro (Kentucky) Medical Society, and the Montgomery County (Dayton, Ohio) Medical Society.

A native of New Albany, **Dr. Cecil Patterson** has opened an office for the practice of medicine in Charlestown. He is a graduate of the University of Louisville School of Medicine.

Dr. A. Jerome Sparks has been appointed chief of the urology section of the new Veterans Hospital which is nearing completion in Fort Wayne. Doctor Sparks has been associated with the VA hospital in Indianapolis, and prior to that he had practiced in Fort Wayne from 1928 until 1947.

Dr. Harris B. Shumacker, Jr., professor of surgery at Indiana University School of Medicine, was elected president of the American Association of University Surgeons recently. The Indiana University School of Medicine was voted into the national group at this meeting, which was held in Philadelphia.

Dr. George Love is now in the private practice of anesthesia at the Methodist Hospital in Indianapolis. Doctor Love is a 1939 graduate of Indiana University School of Medicine, and is a veteran of World War II.

Dr. Lester D. Bibler, of Indianapolis, was on the program of the Associated State Postgraduate Committees, which met in Chicago on February 4. His subject was, "The Role of the State Medical Society in Postgraduate Education."

A 1944 graduate of Indiana University School of Medicine, **Dr. Walter H. Hollis** now is in practice at Princeton. He recently completed a residency in obstetrics and gynecology at Indianapolis General Hospital, and is a World War II veteran.

Dr. Carl G. Kuehn, of Indianapolis, has been appointed chief of the division of preventive medicine with the Louisiana State Board of Health, in New Orleans. Doctor Kuehn is a 1941 graduate of Indiana University School of Medicine, and has been associated with the Indiana State Board of Health.

Dr. William J. Schecter, a 1944 graduate of Indiana University School of Medicine, has opened an office at 4036 Wilshire Boulevard, in Los Angeles. He will specialize in obstetrics and gynecology. He is a veteran of World War II, and recently completed a residency at the Indiana University Medical Center.

Dr. Albert Goodrich, of Indianapolis, is now associated with **Dr. Elwood K. Jones** in the practice of surgery in Bridgeport, Connecticut.

Dr. William A. Shuck, who has been in the practice of surgery in Indianapolis, has moved to Madison, where he has established an office.

A 1947 graduate of Indiana University School of Medicine, **Dr. Phillip E. Pennington** has begun a residency in neuropsychiatry at the VA Hospital in West Los Angeles.

The Indiana Association of the History of Medicine met in the Eli Lilly and Company auditorium, in Indianapolis, on March 24. The speaker was Dr. Howard Dittrick, director of the Howard Dittrick Museum of Historical Medicine, of the Cleveland Medical Library. His subject was, "Hospitals of the Arab, the Cleric, and the Crusader."

At the sectional meeting of the **American College of Surgeons**, which was held in Louisville on February 20, the following physicians from Indiana were registered: Cleon A. Nafe, C. H. McCaskey, Russell W. Lamb, John W. Emhardt, Indianapolis; R. G. Ikins, F. A. Loop, M. J. Eaton, G. T. Coloviras, Lafayette; W. L. Daves, H. J. Faul, Dallas Fickas, Evansville; H. C. Johnson, M. L. Curtner, Paul B. Arbogast, Vincennes; Paul E. Haley, South Bend; W. D. Day, Seymour; John C. Drake, Anderson; A. W. Cavins, Terre Haute; W. W. Ayres, Marion; L. F. Beggs, Columbus; F. F. Boys, East Chicago; J. F. Ferrara, Franklin; Raymond Geick, Fort Branch; George M. Johnson, Richmond. Other Indiana physicians may have been present, whose names were not obtained from the register.

ARMY CIVILIAN INTERN PROGRAM

Selection of senior medical students for the Army's civilian intern program is proceeding at an accelerated rate since the first of this year, Major General R. W. Bliss, the Army Surgeon General, said recently. To date 52 applicants have been selected. They represent 34 of the country's approved medical schools and will intern in 48 different civilian hospitals.

To be eligible, a candidate must be a potential graduate who will begin an internship between January 1 and December 31, 1950, and must have been accepted for internship training in a civilian hospital acceptable to the Surgeon General.

Successful candidates will be commissioned in the Army Medical Corps Reserve and permitted to complete their internships as officers on active duty with pay and certain allowances of the grade of first lieutenant.

Physicians selected for this training program will serve two years on a duty status for the year or major portion of a year of formal training received.

The Park School Garden Tour will be held on April 29 and 30. The gardens will be open from 1:00 to 6:00 p.m. on both days. Tickets are $2.00, and may be obtained from Mrs. Leslie S. Lee, 3766 Totem Lane, Indianapolis.

MEDICAL OPENINGS IN PACIFIC ISLANDS

The Department of Interior will assume shortly administrative responsibility for Guam and American Samoa, and also for the Trust Territory of the Pacific Islands. These island areas are now under the jurisdiction of the Navy Department. Replacements of naval officers, including medical officers in the hospitals, field stations and public health department, will take place soon. Medical positions for the governments of these three areas have been created and civilian physicians may apply. Positions will be open for physicians, public health officers and hospital administrators. Further information in regard to medical openings in the Pacific Islands may be obtained from the Division of Territories and Island Possessions, Department of the Interior, Washington 25, D.C.

SECOND ANNUAL ASSEMBLY AMERICAN ACADEMY OF GENERAL PRACTICE

The American Academy of General Practice held its second annual assembly in St. Louis, February 20 through 23. The attendance set a new record. There were 5,072 registrations for the four-day convention, with every state represented, and with visitors from Canada and South America. Indiana was very well represented.

The scientific program was given by such men as Drs. Henry Bockus of Philadelphia, Curtis of Ann Arbor, Zollinger of Columbus, Howard Rusk, Joslin, and many other outstanding medical authorities in the various fields. Dr. Philip Thorek, who spoke at 11 A.M. on the last day, was enthusiastic in his praise of the large attendance at every scientific session up to and including the last.

One hundred sixty-seven exhibitors were unanimous in their enthusiasm. After the first assembly in Cincinnati last year, the entire 167 booths were sold in forty minutes.

On Wednesday night a banquet was attended by several thousand doctors and their wives. Three banquet rooms had to be utilized. At this occasion the speaker of the evening was Allan Stockdale, the "pitching parson," who gave a masterly speech on the "Courage of Freedom." An unexpected short talk was given by Dr. Andy Hall, the eighty-six year old physician who was selected "General Practitioner" of the year.

Next year's assembly will be held in San Francisco. Plans are already being formulated to conduct a program of special interest to all the General Practitioners of the country. It was announced that the new Journal "GP," the journal of the Academy, will start with its first issue in April.

A.M.A. WASHINGTON OFFICE NEWS

Government Surplus Potatoes were refused last week by D. R. Youell, President of Hiwassee College, a 200-student school located in Tennessee. The Dean said, "We'll either raise our own potatoes or buy them at the local market price. We would like to take the lead in putting a stop to this sort of government paternalism. An even greater need than Hiwassee's for potatoes is for individuals and institutions to let the federal government know that it is becoming increasingly difficult to distinguish between government charity and socialism."

Army. The Army has recommended against construction of a new building to house the Army Institute of Pathology. It now proposes that the Institute be operated in connection with Walter Reed Hospital in Washington, in the interest of economy and efficiency. The House Armed Services Committee already had approved $350,000 (Report 1620) for initial work on a new building at Forest Glen, Maryland, just outside Washington.

A.M.A. Witnesses Point Flaws In Disability Clause. Three official spokesmen have presented A.M.A.'s arguments against the permanent and total disability clause of H. R. 6000, social security extension bill. They are Dr. James E. Paullin of Atlanta, Ga., Dr. R. L. Sensenich of South Bend, Ind., and Dr. Gunnar Gundersen of LaCrosse, Wis., who testified February 28 before the Senate Committee on Finance. They stressed three points: 1. Determination of permanent and total disability would strain the relationship between physician and patient. 2. This clause would put a cash premium on malingering and deprive patients, perhaps unconsciously, of the "will-to-recover," recognized as an important therapeutic factor. 3. Restrictions would inevitably be relaxed, bringing more and more people under the benefits and stimulating socialized medicine.

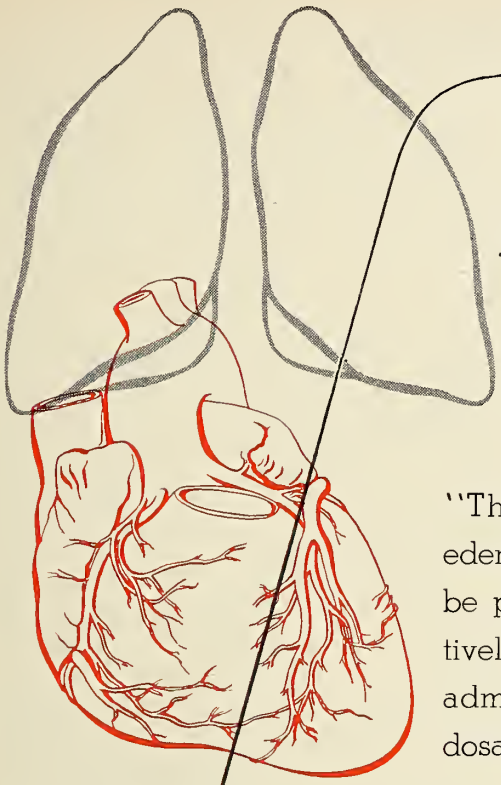
Insurance Witnesses Say Clause Is Impractical. John H. Miller, vice president of Monarch Insurance Company, and Edward O'Connor, managing director, Insurance Economics Society of America, agreed with the A.M.A. that the permanent and total disability clause would be inoperative and a threat to the relationship of physician and patient. Mr. O'Connor said insurance statistics are evidence that "the claim situation under this clause couldn't be controlled." He noted the vague and conflicting wording of the law regarding additional income which a beneficiary would be allowed to earn. "Obviously," he said, "this ($50 per month limit on earnings) means a very strong incentive for the disabled to stay disabled and retire." Mr. Miller made the point that "if the incentive to remain disabled is strong enough the duration of disability for which the compensation is paid will be substantially increased despite the best of claim administration."

VA Tightens Up On Non-Service Connected Cases. Its current economy campaign is giving Veterans Administration an opportunity to start solving a long-standing problem—the treatment of veterans whose injuries and illnesses are not service-connected. Up to now a high percentage of VA patients have been in this category.

Under the law, VA is "permitted" to treat such patients if beds are available. In practice, the beds have been made available. Important VA officials have complained in private about this practice, but have not had much success in changing it. A VA spokesman said that the personnel cutbacks would have no effect on medical treatment of service-connected cases or of non-service connected cases now in hospitals, but that they "might lessen the number of non-service connected patients the hospitals will be allowed to handle." This is the first reduction-in-force to reach VA's medical department. The Administration's overall payroll will be cut by about 7,800, approximately 3,000 of them in medical and hospital services. However, in view of known requirements of VA, it is unlikely that many physicians or nurses will be dropped. Most separations in the medical department are expected to involve non-professional people.

Joint Committee Recommends Voluntary Health Plan. After extensive hearings, a Senate-House Subcommittee has made recommendations to raise the living standards of low-income families (Final Report on Low-Income Families and Economic Stability). Three Democrats and one Republican signed the majority report. It made no mention of President Truman's compulsory health insurance plan, but recommended a program based on "voluntary cooperation of public and private agencies, which will permit all persons who so desire to participate in a system of health insurance." The Committee also favors expansion of hospital construction, federal aid for training of doctors and nurses, expansion of medical schools and public health services.

On other issues the Committee recommended: 1. More liberal benefits for dependent children under social security and expanded and improved health services for school children. 2. Social insurance against permanent and total disability and more Federal money for rehabilitation of physically handicapped. 3. Universal old-age insurance coverage, with higher benefits and pay-as-you-go financing.



PULMONARY EDEMA AND PAROXYSMAL CARDIAC DYSPNEA

"The development of pulmonary edema at night may in certain cases be prevented and in addition effectively treated by intramuscular . . . administration of aminophyllin in dosages of 0.5 Gm."[1]

The diuretic action of Searle Aminophyllin frees the tissues of excessive fluid; its myocardial stimulating action improves the efficiency of heart contractions.

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Barach, A. L.: Edema of the Lungs, Am. Pract. 3:27 (Sept.) 1948.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

COMMITTEE ON PUBLICITY

February 17, 1950

Present: Marlow W. Manion, M.D., chairman; Homer G. Hamer, M.D., James O. Ritchey, M.D.; James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

April 3, 1950—"The Prescription"
April 10, 1950—"The Hair"

LOCAL SOCIETY REPORTS

Clay County Medical Society members held a meeting at the Elks Home in Brazil on February 21. The guest speaker was Mr. Maurice T. Harrell, chairman of the Industrial Board Division, whose subject was "Determination of Disability and Impairment in Industrial Injuries." Eighteen members and guests were present.

Dearborn-Ohio Counties Medical Society members met at the Schenley Cafeteria in Lawrenceburg on January 19, when twenty-nine members and guests were present. Dr. Robert Kehoe, of the Kettering Laboratories, in Cincinnati, was the guest speaker. His subject was "Industrial Hygiene." Representatives of the major industries in both counties were invited to the meeting.

Elkhart County Medical Society members held a meeting at Hotel Elkhart in Elkhart on February 2, when members of the Elkhart County Dental Society were their guests. Dr. Grant H. Laing, of Chicago, was the guest speaker. His subject was "Systemic Nutritional Disturbances as Reflected in the Mouth." Sixty members and guests were present.

Floyd County Medical Society members held a meeting in New Albany on February 10. The guest speaker was Dr. Walter Cole, of Louisville, who gave a report on recent experiments with the newer antibiotics.

Bartholomew-Brown Counties Medical Society members held a meeting at the Elks Club in Columbus on March 8. Twenty-two members were present to hear Dr. C. O. McCormick, Jr., of Indianapolis, speak on "Diagnosis and Management of Occiput Posterior."

Hendricks County Medical Society members met with the Woman's Auxiliary in Avon on February 7. Dr. Karl Ruddell, of Indianapolis, spoke on "Aspects of Medical Care in Europe." Nine members were present.

Howard County Medical Society members met in Kokomo on March 3. Twenty-two members were present to view a film on cervicitis.

Johnson County Medical Society members held a meeting at the Johnson County Memorial Hospital in Franklin on January 11. Dr. J. S. Battersby, of Indianapolis, discussed pathology of the lung; diagnosis and treatment, with special emphasis on surgical treatment. Eighteen members were present.

On February 8 sixteen members were present to hear Dr. G. W. Ritteman, of Columbus, speak on common lesions of the chest, spine, stomach, bowel, gallbladder and kidney, as diagnosed by x-ray.

Another meeting was held on March 8, when Dr. Edwin Lawrence, of Indianapolis, was the guest speaker. Sixteen members were present.

LaPorte County Medical Society members held a meeting at the Hotel Rumely in LaPorte, on January 19. Dr. W. A. Gustafson, of Chicago, was the guest speaker. He discussed the treatment of head and neck pain in general practice. Thirty-six members were present.

At another meeting, which was held at the Sheridan Beach Hotel in Michigan City on February 16, thirty members were present. Mr. Ed. Morris, of Blue Cross-Blue Shield, was the speaker at this meeting.

Orange County Medical Society members held a business meeting at West Baden Springs Hotel on February 7. Eleven members were present.

Parke-Vermillion Counties Medical Society held a meeting at the Vermillion County Hospital in Clinton on February 15. Dr. E. B. Agee, Jr., of Terre Haute, spoke on "Toxemia of Pregnancy." Twelve members were present.

Randolph County Medical Society members held a meeting on February 13 at the Randolph County Hospital in Winchester. Thirteen members were present to hear Dr. Marvin F. Greiber, of Muncie, speak on "Management of Psychiatric Problems."

St. Joseph County Medical Society members met at the Indiana Club in South Bend on February 14. Dr. C. J. Langenbahn, of South Bend, read a paper on "Disease of the Lower Nephron Syndrome of the Kidney."

Vanderburgh County Medical Society members held a meeting at Hotel McCurdy, in Evansville, on February 14. The guest speaker was Dr. Alex Steigman, consultant on clinical epidemiology for the National Foundation for Infantile Paralysis. His subject was "Some Clinical Concepts in Poliomyelitis." Eighty-four members were present.

Wayne-Union Counties Medical Society members met at the Leland Hotel, in Richmond, on January 19. The guest speakers were Dr. E. Vernon Hahn, of Indianapolis, and Mr. Frank Coughlin, attorney, who spoke on the commitment of the sexual psychopath. Forty-four members and twenty-eight attorneys were present.

At another meeting, on February 15, at Reid Memorial Hospital, in Richmond, twenty-four members were present to hear Dr. Katherine Dodd, associate professor of pediatrics at the University of Cincinnati, speak on "Fluid Balance in Acute Illness of Childhood." In addition, a film on saddle-type spinal anesthesia in obstetrics was shown.

Deaths

Joseph E. Moutoux, M.D., of Indianapolis, died suddenly on March 7. He was seventy-five years of age. A graduate of the Louisville Medical College in 1895, Doctor Moutoux had practiced in Indianapolis for the past forty-seven years. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

William B. Wood, M.D., of Oakland City, died January 5 at Passe-a-Grille, Florida, at the age of seventy-two. He was a graduate of the Louisville Medical College in 1905 and had specialized in Urology in his practice at Lynnville, Oakland City and Princeton, returning to Oakland City until he retired in 1946. He was a member of the Gibson County Medical Society, and the Indiana State Medical Association, and was a fellow of the American Medical Association.

Herman L. Bernheimer, M.D., of Terre Haute, died after a brief illness on February 1, at the age of eighty-one. He was a graduate of the Medical College of Ohio, in Cincinnati, in 1899, and was a senior member of the Vigo County Medical Society and Indiana State Medical Association, and a member of the American Medical Association. He had practiced for more than fifty years.

Lafayette Thomas Cox, M.D., formerly of Indianapolis, died on February 19, at the age of eighty-one. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1892, and had practiced in Indianapolis until his retirement a number of years ago.

Walter Thomas Bailey, M.D., formerly of Marion, died suddenly on February 10. He was sixty-four years of age. Doctor Bailey was a graduate of the Meharry Medical College, Nashville, Tennessee, in 1910, and had practiced in Marion for thirty years before his retirement in 1942, when he moved to Indianapolis.

Byron William Marshall, M.D., former Nashville physician, died on February 9 in Phoenix, Arizona, where he had lived for the past three years, following his retirement. Doctor Marshall was a graduate of the Indiana Medical College, School of Medicine of Purdue University, Indianapolis, in 1906, and had practiced in Gary for twelve years, before opening an office in Nashville.

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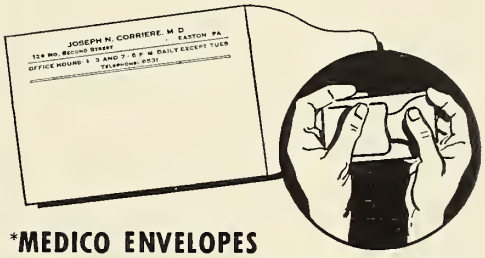

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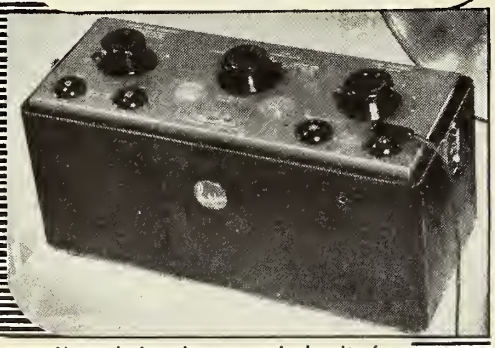

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It would be appreciated if you would furnish us the names and addresses of any persons who might be interested in such employment. This office will then furnish them further information. Candidates interested in applying immediately may complete and forward to me Standard Form 57. Copies are available at your local post office.

Your cooperation and assistance in this matter will be greatly appreciated.

Very respectfully,

B. F. Burdick
Chief of Office
The Panama Canal
Washington 25, D.C.

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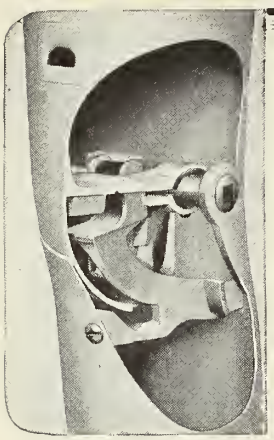

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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

SOCIETY AND ITS CRIMINALS. By Paul Reiwald, reader in criminology in the University of Geneva; translated and edited by T. E. James, barrister-at-law. 315 pages. $4.50. International Universities Press, Inc., New York City, 1950.

PRIMER OF ALLERGY. By Warren T. Vaughan, M. D., Richmond, Virginia. 3rd edition. 175 pages. Price $3.50. The C. V. Mosby Company, St. Louis, 1950.

PATTERNS OF PANIC. By Joost A. M. Meerloo, M.D., former member Netherland Red Cross Committee, instructor in psychiatry, Columbia University. 120 pages. Price $2.00. International Universities Press, Inc., New York City, 1950.

INTRODUCTION TO PSYCHOSOMATIC MEDICINE. By C. Alberto Seguin, M.D., professor of psychosomatic medicine, University of San Marco, Lima. 320 pages. Price $5.00. International Universities Press, Inc., New York City, 1950.

BRAIN AND BEHAVIOUR. Induction as a fundamental mechanism of neuro-psychic activity. By N. E. Ischlondsky, M. D., New York City. 182 pages, with 46 illustrations. Price $7.00. The C. V Mosby Company, St. Louis, 1949.

CARDIOVASCULAR DISEASE. Fundamentals, Differential Diagnosis, Prognosis and Treatment. By Louis H. Sigler, M.D., attending cardiologist and chief of cardiac clinic, Coney Island Hospital; consulting cardiologist, Rockaway Beach Hospital: consulting cardiologist, Menorah Home and Hospital for the Aged. 551 pages, with 149 illustrations. Price $10.00. Grune & Stratton, New York, 1949.

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8 Ed., Phila., Lea & Febiger, 1946—P. 241, 247.

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Vol. 1, 2 Ed., Balt., Williams & Wilkins, 1944—P. 31.

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2 Ed., Phila., W. B. Saunders Co., 1947—P. 735, 736, 737.

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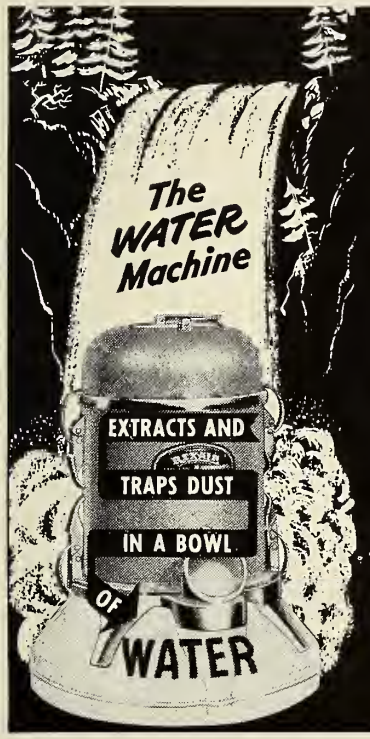

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Books

BOOK REVIEW

OPERATIONS OF GENERAL SURGERY. By Thomas G. Orr, M.D., Professor of Surgery, University of Kansas School of Medicine, Kansas City, Kansas. Second Edition. 890 pages with 1,700 step-by-step illustrations on 721 figures. Price $13.50. W. B. Saunders Company, Philadelphia, 1949.

This is the second edition and has been enlarged and amplified to describe and illustrate many new techniques and recently developed operative procedures. It contains 864 pages of text as compared with 702 pages of the first edition. There are 721 figures with 1,700 step-by-step illustrations as compared with the first edition's 570 figures and 1,396 step-by-step illustrations. The text is clear and concise.

This volume includes a large number of procedures not contained in the former edition. Among these are illustrations and descriptions of a new type of finger amputation, Callander's amputation of the leg, a new method of pedicle grafting of feet and ankle, a procedure for excision of decubitus ulcers, and several new techniques for surgery of the hand and repair of tendons.

The thoracic section has additions dealing with decortication of the lung, segmental pulmonary resection, and a new technique for pneumonectomy.

Surgery of the breast is amplified by description of excision of intraductal papilloma of the breast, and by a method for plastic repair of hypertrophied breasts.

The chapter on blood vessel surgery describes the nonsuture anastamosis of blood vessels, portcaval shunts, interruption of deep veins for thrombotic complications, aortic embolectomy, and closure of patent ductus arteriosus.

The section on wounds is well illustrated with new diagrams on closure of incisions by use of steel wire.

There are several added descriptions of operations for esophageal diverticulum and for resection of carcinoma of the esophagus.

The author's technique for total gastrectomy and Dragstedt's vagotomy are additions, as well as new illustrations for resection of tumors of the liver, and the newer operations for repair of strictured bile ducts.

Resection of irreducible intussusception and the Wangensteen loop colostomy are newly described. Ileostomy and colectomy for ulcerative colitis are well illustrated. New illustrations for one-stage resection of the right colon, and end-to-end anastamosis of the colon are included.

Resection of the recto-sigmoid with preservation of the lower rectum and anus, and the removal of polyps of rectum and colon are also new.

The hernia chapter describes William's repair of sliding hernia, and the hernia operations which utilize Cooper's ligament are well described and diagramed. The repair of incisional hernias is amplified and closure of defects of the abdominal wall with pedicled fascial flaps is included.

New peripheral neurological procedures include celiac ganglionectomy, combined subdiaphragmatic and supradiaphragmatic sympathectomy and splanchnicectomy, and carotoid sinus denervation.

Splenectomy through a combined thoraco-abdominal incision is described.

The section on correction of congenital defects has added to it the procedures for esophageal atresia and tracheo-esophageal fistula, congenital atresia of the bile ducts, imperforate anus, patent ductus arteriosus and other defects of the aorta and its branches.

The chapter on gynecological operations is enlarged by a description of the Manchester operation.

In addition to the above-listed new procedures, the volume retains most of the standard operations of the first edition. The illustrations are excellent. This work will be an important addition to the library of the general surgeon.

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VOLUME 43 MAY, 1950 Number 5

SIGNIFICANCE OF OCULAR VASCULAR ACCIDENTS*

WILLIAM L. BENEDICT, M.D.

ROCHESTER, MINNESOTA

The Author:

Doctor Benedict graduated from the University of Michigan School of Medicine in 1912, and served the following two years as resident in ophthalmology at the University Hospital in Ann Arbor. In 1917 he became head of the Section on Ophthalmology, Mayo Clinic, in Rochester, Minnesota, and in 1919 became Professor of Ophthalmology, University of Minnesota Graduate School of Medicine, Mayo Foundation. He is a fellow of the American College of Surgeons, and of the American Academy of Ophthalmology and Otolaryngology.

IN THE study of disease of the vascular system, the circulation of the retina has received considerable attention because of the visibility of the vessels and the ease with which the vascular changes and the results can be followed. While the vascular system of the retina follows the general pattern of artery-arterioles-capillaries-veins, the absence of free anastomoses constitutes a vascular pattern that is unique, in that a single artery and vein carry the blood supply to and from certain areas of the retina and interference with one of the vessels in this system in this area causes a depletion of blood or excessive congestion that results in definite local pathologic changes characteristic of vascular occlusion. These changes may be clearly seen and studied by means of the ophthalmoscope.

The physiologic plan of the circulation of the retina in man consists of the central artery of the retina which breaks up into four retinal arterioles. These are accompanied by four retinal veins which lead into the central vein of the retina, which usually enters the cavernous sinus. The central artery of the retina is derived from the ophthalmic artery, which is a branch of the internal carotid. Immediately after the ophthalmic branch is given off, the diameter of the carotid decreases from 5.4 mm. to 3.8 mm., a factor favoring the maintenance of high pressure in the ophthalmic artery.

Duke-Elder[1] pointed out that when an artery is occluded, the pressure within it builds up to that in the larger branch from which it is derived. In

*Presented at the centennial session of the Indiana State Medical Association, at Indianapolis, September 28, 1949.

the case of the retinal artery, closure of one of the arterioles may cause the pressure to rise to 99.5 mm. of mercury, the pressure of the ophthalmic artery. It is stated by the same author that the mean capillary pressure within the eye is approximately 50 mm. The capillary pressure is not easily controlled because it depends upon a variety of factors in the vascular circulation. A drop in the capillary pressure is brought about by constriction of the arterioles, while on the other hand occlusion of the venous exit causes a marked increase in the capillary pressure. It is thus possible for the venous and capillary pressures to become higher than the normal intraocular pressure with resultant edema, congestion and hemorrhages into the retina.

The intraocular pressure is not stabilized by the retinal vessels but by a different arterial and venous system, and operates independently of the retinal vessels. This is evident in cases of hypertension in which the retinal arteriolar pressure is greatly elevated while the intraocular pressure is not affected. Obstruction to the venous outflow of the retinal circulation, however, may cause a rapid rise in intraocular pressure with congestion of the retina, as well as of the extraocular tissues, giving rise to what is known as absolute glaucoma.

Closure of the retinal vessels with interference of circulation had long been known as the cause of blindness before the actual mechanism of retinal circulation was known and before the process could be visualized by the ophthalmoscope. The ophthalmoscopic picture of thrombosis of the central vein of the retina was first clearly described by von Michel[2] in the year 1878. Since that time, through numerous contributions by von Michel and others, the significance of this retinal picture has been properly evaluated in the literature. Von Michel elucidated and accurately described a disease which to be sure had not been unknown but had been insufficiently defined. The cause is unilateral spontaneous thrombosis of the central vein of the retina. Those afflicted are individuals beyond the age of 50 years who suffer from sclerosis of the peripheral arteries, mild hypertrophy of the left ventricle, and probably pulmonary emphysema, as well. The disease has a very sudden onset, just as does embolism of the central artery. Visual ability is markedly lowered to the level of finger counting. The eyegrounds show bloody infiltration of the optic nerve, large streak hemorrhages in its immediate vicinity and smaller ones out to the periphery. The arteries are poorly filled, the veins are extensively dilated and tortuous, and are dark, blackish red in color. The outcome is either blindness of the eye, if the vein is completely occluded by the organized thrombus, or improvement of the vision, if the thrombus soon frees itself again. But even in the latter case, there remain behind a bright pigmentation of the optic nerve head and tortuosity of the veins.

CLOSURE OF THE RETINAL ARTERIES

Von Michel concluded that the clinical picture of so-called embolism of the central retinal artery can be produced by thrombotic occlusion. Subsequent to an endarteritis superimposed on arteriosclerosis, clotting of the blood results distal to the most markedly narrowed region. Sudden bloody effusion into the retina, the so-called hemorrhagic retinitis, may result either from a wandering thrombus in the central vein or from a proliferation occluding the lumen of the vein. The pathologic factors concerned in obstruction of the central vessels of the retina have received considerable attention. Complete occlusion of the central retinal artery gives a characteristic picture of retinal edema and ischemia of the retina, with almost universal pallor except for a cherry-red spot in the macula. The retinal arterioles become attenuated, practically invisible, and vision may be lowered to complete blindness. Occlusion of one of the arterioles, branches of the central artery, will cause a similar picture in the region of the fundus supplied by that occluded vessel.

Occlusion of the central artery is usually followed by optic atrophy and total, complete blindness. Occlusion of one of the arterioles of the retina may lead to a scotoma in the field of vision subtending the affected portion of the retina. Recovery of vision following occlusion of the central retinal artery has been reported in rare cases.

Closure of the central artery of the retina or of any of the arterioles may be brought about by spasm of the vessel, by organic thickening of the wall of the arteriole, known as sclerosis, or by a generalized narrowing of the arterioles which probably represents the general increased tone of the arteriolar system. These three distinctive types of alteration occur in the retinal arterioles in the different phases of hypertensive disease. Closure of the retinal arterioles may be found at all ages but more commonly in the ages when high blood pressure is most commonly found. The cause of occlusion of one of the arterioles of the retina may be difficult to determine in any particular case but in the absence of vascular changes due to hypertension it may be assumed that the occlusion comes about as the result of the lodging of a thrombus that has been driven into the retinal circulation from without, or from closure of the vessel by the building up of the thrombus as the result of a minor injury to the lumen of the vessel. It is generally believed that, in most cases, closure of the arterioles comes about through thickening of the walls of the vessels as the result of hypertensive disease.

Wagener, Clay and Gipner,[3] in a report submitted to the American Ophthalmological Society in 1946 on the classification of hypertensive diseases of the retina, have designated five stages of hypertensive disease. The first, second and third stages of their classification are concerned with the so-called functional changes in the vessel wall with minor pathologic changes. When generalized arter-

iosclerosis is present, with generalized narrowing of the arterioles, focal constriction in the arterioles, and at times focal arteriosclerosis, there is chronic progressive hypertension as a systemic disorder. Terminal malignant hypertension always is associated with generalized arteriosclerosis and generalized narrowing of the arterioles, with at times focal constriction and arteriosclerosis. It is quite evident from reports in the literature that embolism of the central artery, causing an acute ischemia of the retina, is usually the result of angiospasm.

Hypertension can arise from an increase in the volume or the viscosity of the circulating blood or from increased cardiac output. These factors are said to be normal, however, in most cases of essential hypertension. The rise of blood pressure in these cases depends apparently on the increased resistance to blood flow in the periphery caused by a reduction in the capacity of the general arteriolar bed. In the early phases of the disease this reduction in capacity is the result of functional contraction of the arterioles, rather than of structural changes in their walls with the consequent decrease in lumen. Whether this contraction of the arterioles is due to increased stimulation of the sympathetic motor nerves or to the direct action of a chemical or hormonal substance on the walls of the arterioles has not as yet been definitely demonstrated. When functional contraction of the arterioles persists or recurs at intervals for an indeterminate period, which varies considerably in different individuals, structural thickening of the walls of the arterioles is added apparently to the functional contraction as a factor in reducing the capacity of the arteriolar bed. This anatomic change in the walls of the arterioles, which is primarily hypertrophy of the media, is observed most frequently or constantly in the arterioles of the kidneys, but it is by no means confined to the kidneys and may be observed in many other organs and tissues, such as the voluntary muscles, liver, intestinal wall, brain, retina and choroid.

Gowers[4] wrote in 1876 that "when the retina is free from local disease, there is no reason to believe that the retinal artery and vein differ in this condition from other arteries and veins of the same size, and, therefore, any marked change in their state apart from cerebral or ocular disease may be taken as evidence of a similar change throughout the vascular system."

The conception of retinal arteriosclerosis as a part of general and cerebral arteriosclerosis has been strengthened in recent years by the studies of many observers and it has become increasingly apparent that the lesions observed ophthalmoscopically in the retinal arterial branches are really arteriosclerotic in their characteristics and systemic significations. The so-called retinal arteriosclerosis is a part of hypertensive disease and diffuse arteriosclerosis, and not atherosclerosis.

CLOSURE OF THE RETINAL VEINS

In the first and classical description by von Michel in 1878, two major and one minor factors concerned in the production of retinal venous thrombosis were clarified: first, the toxic condition that produces the endophlebitis or mesophlebitis whence the thrombosis can originate; second, the slowing of the blood stream in the retinal arteries with corresponding slowing of the blood column in the vein, thus permitting fibrin and cells to be deposited at the site of the thrombus; and third, the minor factor, the anatomic malformation of the vein which contributed to the slowing of the blood stream. Gradle[5] stated that "Lauber was probably the first to emphasize the importance of the arterial slowing." Gradle found that in all cases of central vein thrombosis the central artery was markedly decreased in caliber, but whether due to systemic disease or a purely local condition could not be determined. But even though the blood stream be slowed, fibrin and cells will remain in suspension unless there is a rough spot upon which deposits may collect. Verhoeff[6] expressed the belief that such a rough spot is purely endothelial proliferation and that thrombosis in the true sense of the word does not exist. Gradle gave the mechanism of production of retinal venous thrombosis as follows: first, narrowing of the lumen of the retinal artery results in a marked decrease in the rapidity of the blood stream; and second, as a result of a generalized toxemia or sclerosis an endophlebitis or mesophlebitis appears in a vein. This inflammation produces a roughened nodule, primarily probably of endothelial cells that protrude into the lumen of the vein.

The mechanism whereby the veins of the retina become occluded is still the subject of considerable controversy. Klein[7] has written that the mechanisms of occlusion of the central retinal vein may be grouped into four types, as follows: first, occlusion by compression from without the vessel and secondary thrombus formation, as in some types of arteriosclerosis and phlebosclerosis or in tumor metastasis into the optic nerve; second, occlusion by primary thrombus formation in blood dyscrasias, such as polycythemia and thrombocythemia; third, occlusion by stagnation thrombosis following widespread arterial spasms—to this type belongs venous occlusion caused by (a) early spastic hypertension, (b) a surgical procedure or cranial fracture, and (c) congenital heart disease; and fourth, occlusion by inflammatory disease of the venous wall and secondary thrombus formation. On microscopic study of central venous obstruction variations are seen ranging from a thrombus lying within an almost normal vein to complete fibrous atresia. Causative factors may be (a) primary sclerotic changes in the vein wall causing an increasing obstruction; the resulting slowing of the circulation may be accentuated by arteriosclerosis; and (b) infective changes in the vein wall with secondary

thrombus formation. These may be associated with influenza, syphilis or pyemia.

In venous obstruction, the main back-pressure effect will be on the capillaries and the postcapillary venules in the form of capillary hemorrhages, micro-aneurysms and soft exudates, and in the visible veins as stasis and anoxemic degeneration (sheathing and fatty degeneration of the outer coat). Capillary hemorrhages or aneurysms alone indicate incomplete blockage of mild degree—massive hemorrhages a more complete obstruction. McPheeters,[8] writing on the subject of thromboembolism and thrombophlebitis, stated: "Both clinically and pathologically phlebothrombosis and thrombophlebitis are in a sense one and the same thing. They both mean a closure of the lumen of the vein with a blood clot. It is just a question of the degree of the inflammatory phase of the condition present. Phlebothrombosis means just a closure of the vein with a simple blood clot like a postmortem clot. It is not fixed to the wall of the vein at all and stays in position only because of the stagnation of the blood stream and the branching of the veins. On the other hand, thrombophlebitis means that there is an inflammatory phase present and because of this the thrombus is thick and adherent to the walls of the vein so that seldom does it break loose and cause an embolism. This happens only as the inflammatory part of the picture disappears and the thrombus terminates in the simple red clot. In the presence of stagnation the thrombus may extend far along the vein and thus gradually pass over into the phlebothrombosis and it is this part that gives the embolism. The true phlebothrombosis carries a very high incidence of mortality. The true and marked case of thrombophlebitis has a very low one. On the other hand, it causes much morbidity and oftentimes results in crippling for life."

Since thrombosis of the central vein and its tributaries is a rather frequent occurrence in patients having arteriosclerosis and hypertension, the clinical significance of the occlusion of the retinal vessels is at once apparent. While occlusion of the vessels may produce blindness, only seldom does the disease set up a condition within the eye which necessitates enucleation. Consequently, comparatively few cases are available for pathologic study in the early stages of the disease.

Thrombosis of the central vein of the retina or one of its branches or tributaries is the rather frequent cause of loss of vision in middle-aged or elderly individuals. It frequently is considerably greater among patients with relatively benign hypertensive disease than it is in the general population or in patients with severer forms of hypertensive disease. The majority of patients who present themselves with loss of vision due to thrombosis of a retinal vein are in other respects in relatively good physical condition, so that the loss of vision is their primary concern. The average age of occurrence of this type of vascular accident is 57 years, so that many of these patients have the expectancy of a number of years of active life. It would seem, therefore, that any form of treatment would be worth-while which would offer a chance of restoring useful vision to the affected eye.

It would appear from the reports in the literature that treatment with heparin when instituted early gives excellent results. Heparin is the most active of all anticoagulants. It is nontoxic and its use in no way interferes with analysis of the blood. It is believed that heparin prevents further increase in the thrombotic process, thus permitting greater canalization and resumption of the normal function of the vein.

Very encouraging results with the use of anticoagulants have been reported during the past ten years. The introduction of dicumarol has greatly simplified the treatment. The combination of heparin and dicumarol gives theoretically the best results.

The restoration of vision following treatment depends upon the extent of the interference with the blood flow and the duration of the obstruction before treatment is begun. It is quite uncommon to note improvement in the condition of the vessels even after the hemorrhages have been absorbed, and circulation is re-established by canalization or anastomoses. The best results can be expected in those having only mild arteriosclerotic changes and the poorest results in cases of rapidly progressive hypertensive disease.

A review of the data on cases of closure of the retinal vessel encountered at the Mayo Clinic has shown that the ophthalmoscopic picture of the pathologic fundus in hypertensive disease and in arteriosclerosis is a fair indication of the condition of the vascular system as a whole, and the finding of severe vascular spasm and advanced arteriosclerosis in the retinal vessels is an indication of a systemic vascular disorder of grave significance. Thrombosis of the retinal vessels is not unlike thrombosis in other parts of the body. However, there is probably this difference, that in the retinal vessels there is more often an inflammatory element. In any case the prognosis for recovery of vision is grave and the vascular disease is well established throughout the entire system. The fact that the early vascular changes can be seen in the fundus of the eye, oftentimes before any symptoms of vascular disease can be detected elsewhere, makes the ophthalmoscopic examinations of inestimable value.

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SYMPATHETIC OPHTHALMIA

THREE CASE REPORTS

William M. Cockrum, M.D.

Howard C. Slaughter, M.D.

Edward U. Murphy, M.D.

EVANSVILLE

THIS paper presents three cases of sympathetic ophthalmia. It presents nothing new, but serves to remind that the condition does exist, is prevalent today, and is resistant to treatment.

Sympathetic ophthalmitis is defined as "a specific bilateral inflammation of the entire uveal tract of unknown etiology, characterized clinically by an insidious onset, a progressive course with exacerbations, and usually a disastrous termination; pathologically by a nodular or diffuse infiltration of the uveal tract with lymphocytes and epithelioid cells, which almost invariably follows a perforating wound involving uveal tissue."[1]

The disease appears in the injured eye at varying periods from the time of injury; the other eye is affected shortly afterward or at the same time that the injured eye is affected. The injured eye is called the "exciting eye"; the sympathizing eye is the eye that is affected, but has had no injury. The clinical and pathological pictures presented in the two eyes are, generally speaking, identical.

It is a relatively rare disease, with most writers bringing the percentage to about 0.1 to 0.15 percent of clinic patients.[2] Males have sympathetic ophthalmia about twice as frequently as females.[1] Also, the young are more susceptible than the old.[3] Too, curiously enough, most of the cases appear during the winter months.[4] Sixty-five percent of the cases are due to penetrating injuries, accidental penetrating injuries, 25 percent are due to operative wounds, while 10 percent are made up of nonpenetrating contusions.[1] It is very rare for a sympathetic inflammation to arise without a rupture of the globe.[5] It is also rare when suppuration in the injured eye is followed by a sympathetic ophthalmia.[6]

The interval between the time of injury and the onset of the inflammation can be variable. It can be from a few days to a number of years. Nettleship gives his range from nine days to twenty years.[2] However, 90 percent of these usually develop before the lapse of one year from the time of the injury. If the condition does not develop within a three months' period, it probably will not develop; however, the possibility of its incidence exists indefinitely.[1]

We will not touch on the theories of the cause, except to mention that the infective, tuberculous infection, virus infection, and allergic theories have all been presented.[1]

The prognosis of sympathetic ophthalmia is not bad, if the case is obtained early, adequate treatment instituted, and the exciting agent removed. Useful vision is retained and the inflammation subsides in about 60 percent of the cases reported here in the United States.[3] The predominant symptoms are photophobia and transient visual failure.

In the prevention of sympathetic ophthalmia, wounds with delayed healing should be watched carefully, and, of course, steps should be taken to speed up the healing; also, foreign bodies should be removed promptly, as retention of intraocular foreign bodies definitely has an effect on the outcome of these eyes. The one thing to do is to enucleate an injured eye before the characteristics of the disease become apparent in the sympathetic eye.[1]

Treatment will be covered in the handling of the three cases that are reported.

CASE I

Mr. W. N. R. was first seen on November 12, 1948. A steel foreign body had been present in the right eye for forty-eight hours. This was located

between the iris and cornea, at six o'clock near the limbus. There was an active endophthalmitis, with suppuration in the anterior chamber. The patient was immediately hospitalized and given tetanus antitoxin and penicillin, the latter locally and instilled into the anterior chamber. The metallic foreign body was removed without difficulty, with a magnet. He also received penicillin intramuscularly daily. On the first few postoperative days we were of the impression that the man would retain the injured eye, because he had had a purulent endophthalmitis, and for this reason the possibility of sympathetic involvement was considered rather remote. The endophthalmitis improved in three days but the lens became intumescent. Twenty days after the operation a mature cataract was present and vision remained at hand motions. The eye continued somewhat red, but the patient was sent home on atropine December 23, 1948. The separation of lights, at this date, was poor. The vision in his left eye was 20/20, with a mild hyperopic correction. He was seen again on January 6, 1949. There were posterior synechiae present in the injured eye. It was soft, with very few deposits on the cornea. It appeared to be clearer than on the previous date. He was seen again on the twentieth, and the eye continued soft, but the patient stated that the eye was more comfortable. There was very little slit-lamp flare at this time. He was given foreign protein on this date, as on all previous office visits. He was seen again on February 2, about ten weeks after the date of the injury, and the patient stated that the eye was better and that he could see lights much better. He returned on the seventeenth of February, with his eye "mushy" soft, but it was not painful and it was not red. At this time there was a little suspicion of more increase in the activity of the cells in the anterior chamber, and he was told that if the eye became red to return immediately. However, he did not return until March 11, approximately one month after the previous visit. At this time he had deposits on the cornea and some synechiae in both eyes. The vision in the left eye had decreased to 20/30. The patient was immediately hospitalized and an enucleation of the right eye was done. There were a moderate number of adhesions about the posterior pole of the enucleated eye. The conjunctiva was not closed, no implant was put in place, and a compression bandage was put over the eye. Following the operation the patient received intravenous typhoid every other day, penicillin, benadryl and hot packs. He stated that the vision became much worse. The vision was not taken while he was in the hospital. The enucleation was done on March 11, and he was kept in the hospital until April 7. During his hospital stay a great number of deposits were seen in the sympathizing eye, with development of a nearly complete posterior synechia. Lens haze developed and his vision was reduced to hand motion. On April 26 he was readmitted to the hospital, where he was again given penicillin daily and typhoid every other day, with aureomycin and benadryl. His teeth were x-rayed and two questionable teeth were removed. There also were two abscessed roots which were removed. Following this there was a moderate flare-up in his eye. He left the hospital on May 28. On June 9 his vision was 20/400 minus. Most of the exudates had disappeared; the synechiae were still present, and we were unable to improve the vision beyond 20/400. He had had a complete physical examination, all of which was negative, except for a chronic lung condition, which had been present for a number of years. On July 7 his vision remained at 20/400 and was unimproved by refraction. The synechiae had begun to break above. The patient was still on atropine and also on neo-synephrine. The pathology report was returned to us at this time as a definite sympathetic inflammation present in the enucleated eye. We continued to treat the patient, returned him to the hospital, and gave him another course of penicillin and foreign protein in July. On July 28 his vision was 20/100 with a correction of three diopters of hyperopia. He was treated conservatively by salicylates at home and was seen in August with a vision of 20/70. At the end of August he returned and, with the refraction of + 2.00 — 1.50 X 80, the vision was 20/30. In October the vision was 20/30 in the right eye, with very little change in refraction. He has continued to improve, with a recorded vision of 20/25 on January 3, 1950. The patient is quite comfortable, most of the synechiae and pigment that were present have disappeared, and there are no evidences of deposits on the posterior cornea at this time. There is some lens haze. There were no hemorrhages or exudates on fundus examination at any time.

CASE II

The second case that we are reporting is rather unique, in that it followed surgery without injury. On February 26, 1946, a twenty-year-old man, H. D., was seen, who stated that vision had been poor all of his life. At one time he had been told that he had cataracts, but nothing was done for them, as he was doing fairly well, and getting along well in school. Vision in the right eye in the distance was 20/400 and in the left eye 20/200. It could not be improved with refraction. However, near vision, holding reading matter at about four and one-half inches, was recorded as 20/30. He had bilateral nuclear cataracts. The congenital nuclear cataracts included the fetal nucleus. He had good red reflex and, through dilated pupil, a detailed study of the fundus showed no abnormality. Preoperative physical examination was negative. On February 28, 1946, a Barkan linear extraction was done on the right eye; liquid vitreous was present, but the nucleus was removed. Iris was incarcerated in the wound, but the pupil was only slightly drawn up. On April 10, 1946, the eye was quieting. There was some vitreous haze, with a thin secondary membrane. The eye was soft. The vision

was recorded as 20/200. Fixation was quite poor. He had been using atropine, because of a moderate amount of cortical material which was present, and on April 12 he returned, stating that the vision was a good deal worse in the right eye than previously. Slit lamp examination revealed no pigmented cells in the anterior chamber, although there was moderate ciliary reaction. It appeared there was a complete dullness of the red reflex and an area of detachment was seen above. He was seen two days later and the eye was still quite red. It was not painful. Ten million units of typhoid antigen "H" were given intravenously. Four days after this visit a diagnosis of sympathetic ophthalmia in the right eye was made. The light began to bother the other eye about two days later. The patient absolutely refused operative procedure of any type. Synechiae began to form in the left eye. There were no hemorrhages, exudates or papilledema on fundoscopy. He was put on penicillin and intravenous typhoid, and was also tested for sensitivity for lens substance and tuberculin; neither showed reaction. He continued on typhoid, receiving a total of six intravenous doses, and penicillin every other day over about a fifteen day period. By April 9 he began to improve. By this time moderately dense synechiae were forming posteriorly in the left eye. These were quite heavily pigmented. He got along fairly well for a period of about two weeks. The right eye began to become phthisical; the left eye showed less reaction. On May 21 he came in again with the left eye very red and painful. We were unable to dilate the pupil. There was definite evidence of posterior synechia. The patient again refused enucleation. He was put on typhoid and penicillin and continued this for another series of six injections of typhoid, receiving penicillin daily at this time for a two weeks' period. Neo-synephrine and atropine were used, but very little dilation was obtained. By June 10 a very definite waxy deposit was found over the entire lower portion of the cornea of the left eye. There was a decrease in the amount of pigmented deposits seen. The eye began to clear again. By June 27 the pupil began to dilate fairly well. He continued to improve over the next few months. Vision in the left eye, with a correction for hyperopic astigmia, was recorded at about 20/70. The patient was unable to read, as he was using atropine and was unable to accommodate. In the next few months, in spite of the fact that the patient was on atropine, he learned to read fairly well, achieving about 20/30 vision in the eye by holding his paper close. In January, 1948, the eye was examined thoroughly. There were no cells at all in the left eye. There were synechiae present. The pupil was dilated with neo-synephrine and atropine. The synechiae that were present were not broken, but the iris was quite free, considering what the eye had gone through. The right eye was completely quiet. He had good light perception in it. The tension registered ten millimeters of mercury Schiötz in each eye. There was a secondary membrane which occluded the pupil completely on the right. It was comfortable. In August of 1948 he was re-examined and vision of 20/80 without glasses was recorded in the left eye and light perception in the right eye. This vision was for twenty feet. At near he could read 20/30 without glasses and was using atropine only if the eye felt irritable. The right eye, on slit lamp examination, was clear, and there was no discomfort. He was advised that he could continue his education and since that time has completed one and one-half years of college work and is doing fairly well. No further surgery is contemplated in this case.

CASE III

The third case is Mr. E. G., a man of thirty-two, who was seen at St. Mary's Hospital, following a contusion to the left side of his face. When, on February 11, 1949, he was seen in the operating room, he was hyperactive, and was under the influence of alcohol. He had rather extensive damage to his face—a deep laceration over the eye, down over the temple up to the vertex of his skull, several teeth were loosened, there was a fracture of the nose; however, there was no fracture of the orbital rim. The lid of the left eye was severely lacerated. The globe was ruptured, with prolapsed uveal tissue. After a great amount of difficulty the patient was quieted enough that an intravenous anesthetic could be given to him. He took a large amount of sodium pentothal. His blood pressure had been moderately high. After he was anesthetized and about half the wounds were closed, the patient went into shock. He had lost a moderate amount of blood. A rapid closure of the remaining wounds was made and a transfusion and intravenous fluids were started. The patient's blood pressure returned, but his condition remained poor. He was returned to the ward without any repair being done on the eye. During his hospital stay he received atropine in his left eye, and hot compresses. He was seen in the hospital daily for a period of about one week. He expressed a desire to return to his home and have no further surgery done to his left eye. He was discharged from our care and was not seen until he was brought into our office in the custody of the police about one month later, stating that his right eye was bothering him. We learned then that the man had been arrested for disturbing the peace and had been in the custody of the police since his dismissal from the hospital. His left eye was quite red. There were practically no recognizable structures, except a small cornea. The eye was phthisical. The right eye showed a great deal of perilimbal injection, with pigmented K. P. on the posterior cornea, synechiae developing, and the vision was down. Emotionally the patient was very disturbed and we were hardly able to get a sensible answer from him. We informed him that his left eye should be removed. He immediately said that

he wished to get in touch with his family before anything more was said or done to him. He left our office and we later found that this man did have a sympathetic ophthalmia, and that the exciting eye had been removed. We have only a history stating that the man did have good vision prior to the injury in the right eye. We were unable to obtain a visual acuity on the man on the visit in our office because of his emotional state.

SUMMARY

This paper presents three cases of sympathetic ophthalmia developing after penetrating wounds to the globe. However, it shows a diversification of the types of injury: the first a penetrating wound without incarcerating uveal tissue and with a purulent infection; the second with very extensive damage and incarceration of the uveal tissue; the third case with complete destruction of the eye from a penetrating wound. The time element in the first case was approximately four months; in the second case approximately two months; and in the third less than one month. The first two cases were very fortunate and responded very well to treatment, which was rather nonspecific. No follow-up has been obtained on the third case. This simply shows the possibilities in sympathetic ophthalmia. It is a condition always to be kept in mind, regardless of how slight the injury to the eye.

The first case could definitely be considered in the older age group, the second case in the younger group, and the third case in the middle-age group. Also, all three were males. One other thing may be pointed out. The first case developed sympathetic ophthalmia approximately four months after the time of injury and about one month after the so-called "danger" period. It would have been very easy, we think, to have prevented a great amount of the difficulty in the first case if the patient would have reported to the office more regularly. He was quite reluctant to have anything done to his eye at any time, and was cooperative only after the vision in the better eye was reduced to 20/400. All of these cases developed their symptoms between the early part of February and the middle of April.

908 Hulman Bldg.

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ANGIOSPASM

(General Application)

CARL J. RUDOLPH, M.D.

SOUTH BEND

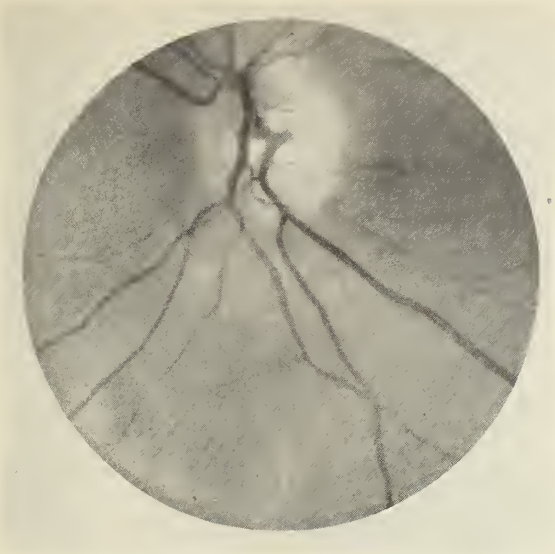
THE general circulation is made up of the circulation to many organs. The circulatory system consists of arteries, capillaries and veins which are under the control of the vasomotor system. Local circulatory disturbances are of two kinds: (1) Vasomotor or neural, and (2) Mechanical. Mechanical obstruction may be due to a thrombus or embolus, to vascular wall changes, and to pressure from the outside.

G. Ricker[1] described vasomotor stimuli as follows: First, a weak stimulus causes an increase in blood flow as a result of dilator stimulation. Secondly, a somewhat stronger stimulus causes a decrease in blood flow due to constrictor stimulation. Third, a strong stimulus causes paralysis of constrictor fibers and dilatation due to dilator stimulus. The dilator fibers are soon paralyzed and above the dilation the artery constricts, resulting in a slowing of the blood to complete cessation.

Active or Simple Hyperemia. Mild dilator stimulation only is found in a functionally active organ. Related to this form of hyperemia is the condition known as a compensatory hyperemia, which exists in a paired organ after removal or destruction of the other organ.

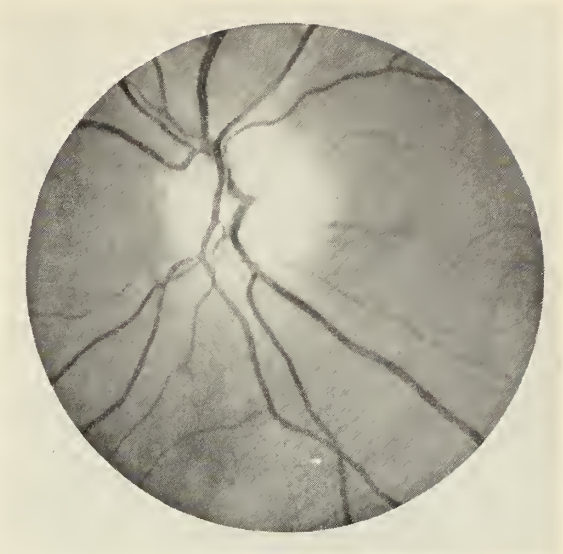
Peristatic and Prestatic Hyperemia. This is a hyperemia with a slowing of the blood flow. In this form of hyperemia there is a stimulation of the dilator fibers and a varying degree of inhibition of the constrictor fibers. Central to this area of dila-

Figure 1



During spasm of central retinal artery, right eye. Note especially inferior nasal branch. (Courtesy Mayo Clinic.)

Figure 2



After spasm of artery. Same eye as in Figure 1.

tion the artery is constricted; the severity of this constriction determines the rate of blood flow or its complete stasis. Peristasis is the less severe and is that condition which results in fluid escaping the vascular wall, resulting in edema. This form includes neuroparalytic hyperemia and inflammatory hyperemia.

Prestasis is more severe although circulation is still maintained. This form of hyperemia is characterized by the passage of red blood cells through the capillary wall or hemorrhages of varying extent.

Stasis. The central constriction here is still more severe and the circulation is barely maintained or is at a complete standstill. Activity of the vasomotor fibers in the affected area is completely lost; vessels are relaxed and circulation is at a standstill. The capillaries are filled with red blood cells, the fluid has been lost. The blood does not clot nor does it pass through the vascular wall as activity has ceased. In case circulation is reestablished the blood cells easily separate. Stasis, if long continued, results in necrosis or an anemic infarct. The result is dependent upon two factors, the type of tissue supplied and the duration of stasis. Some tissues remain viable longer than others; for example, brain tissues remain viable for a few minutes, the retina of an eye for about thirty minutes, the kidney for one hour, striated muscle for three hours, and skin for several hours.

Mechanical Disturbances. These are divided into two classes: first, those on the outside of the vessel, such as an exudate or tumor; and secondly, those inside the vessel, such as a thrombosis, embolus, arteriosclerosis and endarteritis obliterans.

W. Hueck[2] has demonstrated that the protoplasm of the endothelial cells of the capillaries and the basement membrane is capable of undergoing a temporary liquefaction, probably due to anoxemia, which permits the loss of fluid in peristasis and also the red blood cells by diapedesis in prestasis.

H. Elwyn[3] classifies the results of circulatory disturbances as follows:

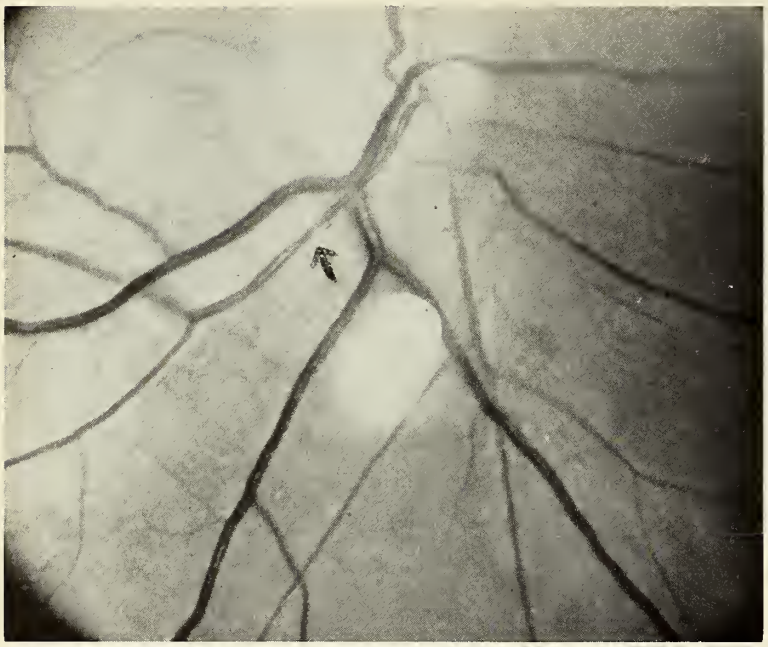
1. Changes resulting from a chronically deficient oxygen supply; (a) Fat and lipoid in the tissues; (b) Hyalin deposits.

2. Changes in the extravasated blood: (a) Decomposition of the red corpuscles, with the formation of hematoidin and hemosiderin and their removal by phagocytes, which are also active in engulfing and removing fat, lipoids, and hyalin; (b) Organization of a large hemorrhage by the growth of fibroblasts and vessels into it, until finally a scar is formed; and (c) Formation of a connective-tissue capsule around a hemorrhage too large to be completely organized, the blood within the capsule gradually liquifying until a cyst is formed.

3. Changes in the infarcted area: The infarct undergoes organization and is gradually converted into a scar. In some organs, such as the brain, the infarct undergoes liquefaction and an area of softening results.

4. The development of a collateral circulation to circumvent the obstruction: (a) By the dilatation of anastomotic vessels already present; (b) By the dilatation and growth of capillaries and small vessels until they are of sufficient size to maintain

Figure 3



Arrow points to segmental vasospasm of inferior temporal artery, right eye. (Courtesy of Northwestern University Eye Clinic.)

the circulation; and (c) By the formation of new connecting vessels.

Vasoneurotic Diathesis. Some people have an especially labile vasomotor system. In response to various stimuli, especially cold, to certain drugs, such as nicotine, and, in some cases to certain foreign proteins, those persons show signs of spasm involving the peripheral vessels, with resulting stasis of the capillary circulation. Normal difference in temperature between that taken orally and that of the extremities is three or four degrees. Vasoneurotic persons show differences as high as ten degrees. The use of nicotine, as in smoking a cigarette, will cause a further drop in these persons of six to twelve degrees, whereas in normal persons there may be a drop of four to five degrees. Oscillometric readings are low. The pulse of one or both posterior tibial arteries may be weak. Microscopic study of the capillaries of the nail folds shows narrowing of the arterial limb of the capillary loop, with stasis, small aneurysms and hemorrhages in a number of areas. Ascorbic acid of blood may be low even in persons receiving a normal diet. Basal metabolism is frequently low. Other pressor tests may be employed; the aforementioned are the more common.

W. V. Duggan[4] reminds us that in the hyperglycemia of diabetes glucose is abundant, but insulin for the complete oxidation of glucose is lacking. In a rigidly controlled case of diabetes glucose is present and insulin is available, but arteriolar constriction occurs, due to the hemostatic liberation of epinephrine secondary to the fall of blood sugar. This decreases the availability of oxygen for the tissues by obstructing the flow of blood to the capillaries and tissue anoxia occurs. This factor is mentioned because all of the pathologic lesions produced in nervous tissue by insulin are similar to those produced by oxygen deficiency.

N. Pines[5] has described what he calls a physiological angiospasm, i.e., a small constriction of short duration with no pathologic repercussions.

Diseased conditions thought to be caused partially or totally by angiospasm are quite numerous. Following is a partial list: (1) Raynaud's Disease, (2) Multiple sclerosis, (3) Angina pectoris, (4) Bell's palsy, (5) Urticarial lesions, (6) Central angiospastic retinopathy, (7) Epilepsy, (8) Some forms of coma, (9) Numbness or paralysis of an extremity, (10) Angioneurotic edema, (11) Traumatic angiospasm, (12) Intermittent claudication and, (13) Angiospastic hypertension.

Factors which may be *responsible* for or aid in precipitating angiospasm are: (1) Histamine or histamine-like substances, (2) Lead poisoning, (3) Allergy, (4) Bacterial toxins, (5) Virus, (6) Venoms, (7) Nicotine, (8) Adrenalin, (9) Cold air, (10) Toxemia of pregnancy, (11) Ovarian insufficiency, (12) Lack of cevitamic acid, (13) Focal infections, (14) Psychosomatic disturbances, (15) Quinine.

TREATMENT OF ANGIOSPASM

1. Eliminate etiology, if possible.
2. Amyl nitrite.
3. Phenobarbital.
4. Papaverine (intravenously ½ gr. b.i.d., if severe).
5. Typhoid vaccine.
6. No smoking.
7. Nitroglycerine (1/100 gr. b.i.d.).
8. Allaying fears.
9. Erythrol tetranitrate (grs. ½ q. 4 hr.).
10. Calcium gluconate to decrease permeability of capillary wall (10 cc. 10% sol. daily for week).
11. Histamine (.275 mgm. ampoules i.v.).
12. Mecholyl.
13. Neostigmine bromide (Parasympathomimetic, 7.5 to 15 mg. per os. t.i.d.).
14. Thyroid when basal metabolism is low.
15. Estrogen if an ovarian disturbance exists.
16. Heat.
17. Use of dependent position of extremity.

18. Heparin or dicumarol to reduce viscosity of blood cells.

19. Whiskey.

Cohen[6] showed by animal experiment that after sudden occlusion of a main vessel the dangers of gangrene may be averted or minimized by interrupting vasoconstriction impulses. White,[7] therefore, recommends novocaine paravertebral injections at the very first evidence of ischemia. (Possibly a retrobulbar injection of novocain and hyaluronidase in the area of the ciliary ganglion would benefit angiospasm involving the eye.)

Coller and Maddocks[8] have attempted to explain angiospasm on a physiological basis. They classify their patients in the following categories: (1) Organic occlusion alone; no spasm, or a very slight amount. This group includes the majority of patients with peripheral arteriosclerosis, senile or diabetic, and far advanced thromboangiitis obliterans. (2) No organic obstruction: pure spasm. The best examples are Raynaud's disease and vascular spasm associated with other conditions, such as anterior poliomyelitis. (3) Some organic occlusion and a variable degree of "superimposed spasm." Early and moderately advanced cases of thromboangiitis obliterans and early arteriosclerosis fall into this class.

Doctor Givner[9] reports a case of each of three angiospastic conditions: (a) Evanescent retinal spasm producing visual disturbance in a patient with so-called "angioneurotic diathesis," (b) Disseminated angiospastic retinopathy, and (c) Angiospastic episodes of hypertensive retinopathy.

DeBakey[10] describes a technique of novocain block of the sympathetic ganglia for the lower extremities. Five cc. of a 1 percent procaine hydrochloride solution is injected into the retroperitoneal space where the sympathetic chain lies. A satisfactory injection is shown by the fact that within a few minutes after completion of the procedure the skin of the extremity of the vasospastic side becomes warm and the superficial veins appear more prominent. Pulsation of the peripheral vessels, such as the dorsalis pedis and posterior tibial arteries, returns or becomes stronger.

Gurdjian and Walker[11] reported that in biopsy studies of six cases of traumatic vasospastic disease of the hand no demonstrable organic change in the capillaries and arterioles of the finger tip had been demonstrated. In this respect the condition is similar to the pregangrenous stage of Raynaud's disease. Most of their cases had been in workers who used a pneumatic drill. G. de Takats of Chicago, in the discussion of this paper, stated his belief that a peripheral neuritis was the primary cause.

Heinbecker and Bishop[12] contend that the major factor in spastic vascular disease is inherent in the walls of the vessels themselves and not primarily the result of any dysfunction of their innervation. They illustrate their contention by the fact that surgical removal of the nerve supply of the limbs which exhibit the Raynaud's syndrome does not prevent the development of the attacks in well advanced cases on exposure to cold or an emotional episode. The explanation offered is that the attacks are now initiated by the action of epinephrine on sensitized blood vessels.

Laufman, et al,[13] after reviewing the literature "on the pathological physiology of peripheral vascular occlusion, maintain that the mesenteric vessels behave no differently than the branches of mainstem vessels in other parts of the body." Their micrometric studies of the mesenteric vascular tree led to the following conclusions: (1) Vasospasm generally accompanies mainstem vascular occlusions. (2) In venous occlusion there is a marked arterial spasm and a venous dilatation. (3) Following release of venous occlusions, the artery remains in a state of moderate spasm for a considerable time. This phenomenon has been termed "residual spasm." (4) In arterial occlusion there is a marked arterial spasm and a concomitant venous spasm. (5) Following release of arterial occlusions, grossly visible reactive hyperemia occurs, but during this state the precapillary artery remains in spasm. (6) "Sludge" formation (Knisely) is seen in the smaller vessels during both arterial and venous occlusions. Minute thrombi form easily in the spastic vein during arterial occlusion and may propagate, thus accounting for segmental venous thrombosis in arterial occlusive diseases. This observation makes it unnecessary to postulate the presence of periarterial inflammation as a venous irritant in the production of venous thrombosis.

Lehman[14] suggests that Coller's diagnostic test for vasospasm (elevation of the environmental temperature) may have therapeutic possibilities in treating acute arterial spasm.

L. Lichtwitz[15] describes attacks of angina pectoris as coming on most frequently while at work and during cold weather. The output of blood during work increases almost 500 percent, or from five liters to twenty or twenty-five liters, and cold causes an increase of about 200 percent. Any of the three following conditions may contribute to the onset of attacks of angina pectoris: (a) Spasm of the coronary artery, (b) Nonappearance of the dilatation which is physiological. (This necessitates greater consumption of 0_2 on the part of the heart as the necessary output of blood is carried by an acceleration of the heart rate instead of by a higher volume per beat.) (c) Nonappearance of an increase of circulating blood volume from storehouses in the spleen, liver, et cetera. Enlargement of the spleen or liver may be found during or after an attack of angina pectoris.

Montgomery and Ireland[16] report the case of a nine-year-old boy upon whom they operated thirty-four days after he had fractured the humerus of the right arm, home remedies having failed. Considerable damage of soft tissue ensued at the time of operation. One hour after operation no radial

nor ulnar pulse was detected and the hand was white. Patient was returned to surgery with the thought that the suture over the arteries or wound may have been too tight. When the arteries were exposed it was evident that there was no visible or palpable pulsation in the brachial, radial, or ulnar arteries. All three vessels appeared to be smaller than normal but they showed no microscopic evidence of injury. There was no indication of a thrombus formation and no ligature or suture was around any of the arteries. The wound was left open and warm moist dressings were applied. Recovery was uneventful.

Morton and Scott[17] have found that sympathectomy results in immediate postoperative improvement in intermittent claudication.

Naide and Sayen,[18] quoting from Franklin,[19] state that although the walls of the veins are thinner than the walls of the corresponding arteries, veins also are richly supplied by sympathetic nerve fibers. The smooth muscle of the veins responds to nervous stimuli in the same manner as does the smooth muscle of arteries.

Naide and Sayen[18] describe a patient with a so-called cold allergy *venospasm;* this was found to develop on exposure to cold without development of arterial constriction, which explained the development of cyanosis and pronounced swelling without blanching.

Russek and Zohman[20] report very favorable results in treating angiospastic cerebral phenomena with papaverine. Dosage in some cases was as high as 12 to 18 grains per diem in combination with phenobarbital, ¼ to ½ grain, three to four times daily.

Selfridge[21] states that choline and nicotinic acid are the two known components of vitamin B complex related to vasodilatation.

Smithwick[22] prefers an extraperitoneal approach for his sympathectomies. "It has been demonstrated beyond doubt that if the second or postganglionic portion of the pathway has been divided a compensatory humoral action is approximately three times as great as that resulting from division of the first or preganglionic portion." Hence, it becomes apparent that a surgical procedure should, in so far as possible, interrupt only preganglionic fibers in order to produce maximal vascular relaxation and maximal blood flow to the part, and to minimize residual vasoconstriction due to this humoral mechanism (adrenalin, et cetera).

Stahr[23] states that the autonomic nervous system controls or regulates all innervation of unstriated muscle. It is composed of two opposing components, the craniosacral or parasympathetic system, and the thoracolumbar or sympathetic system. The craniosacral system is given off from the brain stem and the sacral segments, while the thoracolumbar system leaves the spinal cord only between the first thoracic and second lumbar segments.

Taylor and Tondreau[24] suggest that many of the ischemic paralysis cases may have their origin in an arterial spasm.

R. Bernard Pomerantz[25] quotes Göpfert, et al,[26] to the effect that histamine in small quantities is a vasoconstrictor, in large quantities it is a vasodilator.

Fine, et al,[27] using radioactivity-tagged plasma, present strong evidence to refute the capillary permeability therapy of shock by showing that protein losses are negligible, except in the region of injury, and conclude that shock is due to stagnation of blood in peripheral capillaries, a result of the marked vasoconstriction which clinically characterizes the state.

Abramson, et al,[28] found that only hypertonic salt solution produced immediate vasodilatation plethysomographically with a single dose. The constriction of pain is a stimulus stronger than the relaxation of heat.

J. V. Warren, et al,[29] conclude that many vessels of the forearm are not under the control of the sympathetic system. They suggest that the vessels of the skin of the forearm are under the control of the sympathetic nervous system, and that those of the muscle are not.

L. F. Woolley and L. T. Maholich[30] found that acute prolonged vasospasm can be produced by psychic stimuli.

H. Rocke Robertson[31] states that the pallor of the skin in response to fear and anger is an outward manifestation of this function.

M. S. Smith and V. L. Rees[22] showed that prolonged continuous spinal anesthesia provides not only continuous relief of vasospasm, but likewise gives complete relief of pain. Longest continuous anesthesia in this series was for sixty-nine hours and forty-five minutes.

Alton Ochsner and Michael DeBakey,[32] based on recent clinical and experimental investigations, believe that many of the symptoms and signs of thrombophlebitis are due to vasospasm of the arterial and venous systems and that the vasoconstricting impulses originated in the thrombophlebitic segment.

As the result of vasospasm there result increased filtration pressure, relative anoxia of the capillary endothelium, and diminution in the flow of lymph, all of which increase the amount of perivascular fluid.

C. A. Moyer and W. G. Maddock[33] found that tobacco, regardless of its form or the manner in which it is used, produces peripheral vasospasm.

Sie Boen Lian, Batavia, Java,[34] in describing a Chinese patient having angiospasm of vessels in the macular area of the right eye, writes the following: "In these arteries in which the end branches were obstructed by spasm the circulation of the blood stopped. Aggregation of the red cells occurred, accounting for the presence of columns consisting only of plasma. It scarcely seems plausible that the division of blood and plasma within

the vessels should be so abrupt as to give the appearance of red and white alternate consecutive segments."

Harris B. Schumacker, Jr.,[35] reports a case of livedo reticularis cured by lumbar sympathectomy.

J. M. Barnes and J. Trueta[36] report that the spasm affects the main arteries and also the collaterals of the injured limb. Segmented spasm of the main artery of the opposite uninjured limb is also clearly seen in many experimental animals.

H. A. Haxton[37] found clinical evidence to support regeneration as follows: 1. There is a period of complete absence of sympathetic activity for three to eighteen or more months after operation followed by a gradual return in nearly every case (sympathetic section). 2. The period of freedom is longer in ganglionectomy cases and in these the returning fibers have a much greater distance to cover than in cases of preganglionic section.

E. M. Papper and A. E. Imler[38] used diodrast intravenously to show a venospasm of a popliteal vein; also of the external iliac vein which relaxed after lumbar sympathetic block. Proof was found in x-ray visualization.

G. Reid[39] conducted experiments on animals which evidently proved that shed blood could not cause angiospasm.

The ciliary ganglion, according to Albert A. Kuntz,[40] receives its sympathetic component from the cavernous plexus, and from the ganglion arise twelve to fifteen short ciliary nerves which pass forward above and below the optic nerve conveying fibers to the eye, its extrinsic muscles and the blood vessels.

Retrolental fibroplasia, a not unusual finding in premature infants, manifests characteristics which are strongly suggestive of an acute obstructive vascular phenomenon:

1. The earliest finding of an edema of the retina is commensurate with peristasis.
2. Hemorrhage in prestasis, both retina and vitreous, are involved.
3. The degenerative retinal, vitreous and peripheral lenticular changes could easily enough be explained on the basis of anoxia.
4. The onset between the second and fifth postnatal months further lends credence to this hypothesis. The maternal circulation of blood is interrupted at birth normally and an incompetency of the weak premature heart and vascular system may fail to provide sufficient oxygenation adequately to the retina and brain tissues. It must be remembered that nerve tissue is the most susceptible of all tissues to an anoxia.

A symposium on retrolental fibroplasia at the Pan-American Association of Ophthalmology meeting held during the week of March 26, 1950, in Miami, Florida, was headed by Dr. Parker Heath of Boston, Dr. Arlington C. Krause, Chicago, and William Purnball of Montreal. Nothing in this symposium refuted the principles of this theory, which is solely the conception of the author.

CONCLUSIONS

The results of angiospasm are determined by:

1. Organ involved (brain and retina are more liable to anoxemia than skin).
2. Completeness of interruption of blood column.
3. Duration of spasm.
4. Collateral circulation.

I wish to express thanks to Dr. Irving Puntenny of Chicago, and to the Photographic Department of the N.Y.E. & E. Infirmary, and to Dr. J. W. Henderson of the Mayo Clinic, for the use of their splendid photographs.

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CHRONIC CONJUNCTIVITIS, RELATED CONDITIONS AND SYMPTOMS

D. Hamilton Row, M.D.

INDIANAPOLIS

ONE of the most common conditions about the eyes causing symptoms of sufficient degree to bring patients to the ophthalmologist is varying degrees of chronic conjunctivitis. The complaint varies widely as to symptoms with apparently the same physical signs giving quite different interpretation in one sufferer as compared to another. Frontal headache, usually bilateral but occasionally unilateral, is not uncommon, especially in children and young adults. Burning and smarting of the eyes with sometimes associated itching may be found as the chain of complaints in another series of cases, while mild photophobia, especially when going from reduced areas of illumination out into the bright sunlight and often associated with frontal headache, may be complained of by the next patient. Others may have no particular discomfort but are seeking relief from excessive lacrimation and for unsightly redness of the bulbar conjunctiva.

All red eyes are not red because of conjunctivitis, however, which brings to mind one of the basic teachings we all experienced as medical students in that acute glaucoma and iritis were the other two conditions causing red eyes. Actually the majority of cases of chronic conjunctivitis do not have red bulbar conjunctivitides but usually only moderately engorged angular conjunctival vessels.

What are the common causes of chronic conjunctivitis? I think of three main categories: First, eye strain; second, allergic factors; and third, infectious conditions. At least two of these factors are often found to be associated in many cases, so that the mere fitting of glasses is not sufficient to relieve the symptoms, and so the addition of a short history on the allergic potentialities, and in persistent cases conjunctival cultures, may be revealing and helpful.

Given a case of chronic conjunctivitis, what may

be found as complications? Styes, chalazia, blepharitis, pterygia, also varying degrees of corneal involvement, such as limbal or more centrally located corneal ulceration, superficial punctate keratitis, and varying degrees of episcleritis and even scleritis, also partial to complete closure of the nasolacrimal duct system, are not uncommon complications in chronic conjunctivitis.

It is my belief that a large percentage of occluded tear ducts are so affected as a result of allergic edema of the tear duct. This duct, being contained within a bony channel, suffers destruction of its lining epithelium due to the repeated edema, causing in turn pressure necrosis of the lining epithelium of the tear duct. The fact that most occluded tear ducts are patent above the bony duct lends support to this theory.

After the tears can no longer pass on into the nose from the tear sac a blind pouch, which the sac now becomes, makes a secluded place for bacteria to grow. Regurgitation of this infectious material into the conjunctival space favors the establishment of a chronic infectious conjunctivitis. Cultures of the secretions and from the scrapings of the conjunctival surfaces of such an eye will commonly reveal a growth of hemolitic streptococci or pneumococci. An eye so affected if opened surgically would in all probability be lost because of intraocular infection.

The blepharitis cases with sparse lashes and associated dandruff-like crusting at the roots of the lashes, are usually showing such conditions due to refractive errors, often of very small degree, so that unaided vision is a good 20/20, but not infrequently a seborrheic dermatitis affecting the scalp is the underlying background for this condition.

A stye or hordeolum is strictly an acute infection at the root of an eyelash but we also find the term "stye" used to describe a secondarily infected chalazion which should be more exactly described as a "blindstye" or "meibomianitis" and is of course somewhat removed from the lash line of the free edge of the eyelid.

Debility of the tissues of the eyelid develops because of splinting of the orbicularis muscle of the eyelids or a hypertonicity of this circular muscle, which interferes with venous return of blood from the lid and this factor then favors establishment of conditions of the nature of hordeoli or chalazia.

Splinting of the eyelids because of photophobia, pressure of the lids on the eyeball in an effort to overcome refractive errors, or like pressure of the lids to reduce the feeling of scratching of the lids as they move over the cornea, interrupt venous return of blood from the lids and seem to be underlying factors in causing much of the above described chronic conjunctival congestion and related conditions.

THE SHADOW

Carl B. Harris, M.D.

Indianapolis

A SHADOW stalks eye patients and its name is glaucoma. This is a disease characterized by an increased intraocular pressure which usually results in a slow, insidious visual loss. It occurs with a general incidence of 3 percent of all eye patients and is responsible for many of our blind. It is not only a medical but a social problem of deep concern to all.

The patient is fortunate who has an attack of acute glaucoma, in that the symptoms drive him to the doctor, where the diagnosis of a major eye condition is obvious. These symptoms are acute unilateral eye pain; edema of the lids; lacrimation; marked congestion of the conjunctival and episcleral vessels; steamy cornea; shallow anterior chamber; pupil moderately dilated, slightly irregular and fixed; marked loss in vision. The general symptoms are nausea and vomiting, chills, and alteration in the pulse rate. The eye, by touch, as compared with the other eye is hard. This picture adds up to an attack of acute glaucoma. The diagnosis is usually obvious and the prognosis good.

The shadow is the chronic simple type of glaucoma, in which ocular changes are so gradual that extensive and irreparable ocular damage is present by the time the patient seeks medical assistance. An early diagnosis is difficult and all clinical acumen is exercised in establishing the diagnosis. The rewards are manifold. The typical clinical picture comprises the following features: bilaterality; no congestion or pain; the anterior chamber may be shallow; pupils slightly dilated and sluggish; mild increase in intraocular tension; halos about lights; visual loss and alterations in the visual field; optic cupping and atrophy. Early morning headaches are suggestive. The early changes are so slight that only by suspicion is a final diagnosis established. Certainly a visual test is in order on suspected cases and if there is any question, further study is justified. As in most diseases, the best treatment is prevention and only the medical body as a whole can exercise this prerogative.

Treatment is directed to medical attack and if this fails, surgery is usually indicated. The prognosis is fair.

The shadow walks with all eye patients and it is only by constant application of the above principles that this shadow can be attenuated.

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CONSERVATION OF VISION

EFFORTS by the medical profession and by lay organizations in the interest of conservation of vision have been expended over a period of many years. The National Society for the Prevention of Blindness was organized in 1908, and since then has enlisted the energies of laymen and physicians alike in the task of protecting man's most precious sense.

In 1908 gonorrheal ophthalmia was causing one-fourth of all blindness in children, although its preventive has been known since 1881. These facts were responsible for the founding of the society. Today, venereal disease has almost been eliminated as a cause of blindness.

Through the years education and the encouragement of proper laws has done much to decrease the hazards to which eyes are subject in modern industry. Control of the indiscriminate sale of fireworks was one of the achievements of the national society.

During the past few years, even though several causes of blindness have been controlled to a considerable degree, the problem is still large and challenging. The array of preventable causes of blindness shows those causes in different proportions today, but the sum total is still large and is in need of reduction. It is estimated that 420 Americans lose their sight each week, and that more than half of this loss is preventable.

The effective treatment and control of trachoma by sulfonamides has almost eliminated this disease in the past fifteen years. In the same period of time the extension of the length of life has brought a great many more people into the decades of life in which glaucoma is more likely to develop.

As is pointed out by Dr. Carl B. Harris in his article on this subject in this JOURNAL, the chronic simple type of glaucoma is the most common. It is an insidious disease, and may progress through its early stages with only slight headache and a slight failing of vision as symptoms.

A high index of suspicion should be cultivated by all physicians in caring for patients with visual changes. Patients with failing vision should have the cause of the failure determined. Patients should not be allowed to assume that their failing sight is the result of incipient or immature cataract. Delay is necessary if a cataract is present; it is fatal if ocular pressures are increased.

Treatment of glaucoma in the early stages is highly effective. Treatment later can do very little to restore lost vision, since the pressure effects on the retina and optic nerves are mostly irreversible.

QUOD ERAT DEMONSTRANDUM

THE article on public health and preventive medicine, quoted from Kansas in this issue's Medical Panorama, contains meat for thought not only for its contribution to medical pedagogy but also as a commentary on happenings in Britain. We refer especially to the remark that "The private physician is the keystone of any preventive medical program."

Submergence of the practitioner in a government scheme, as in socialist Britain, so that he is no longer a private physician has had dire effects on preventive medicine among that people. Witness testimony by a nonmedico, Harold E. Stassen, in *Reader's Digest* for January, 1950, and we quote:

> "The abrupt deterioration in the treatment of the sick is serious enough but the effect of the National Health Program on preventive medicine is tragic. Public-health work, measures for the prevention of disease, either in existence or planned, have been retarded and even abandoned. . . .
>
> "For example, it is significant that the London *Times* recently pointed out editorially that England lags behind other nations in programs for the prevention and cure of tuberculosis, and that no hint has come from the Ministry of Health of plans for catching up. . . . Scotland had an excellent program called the 'Highlands and Islands Medical Service. . . .' Its doctors and nurses have been swept into the same inelastic national plan, and the carefully developed coordination, which emphasized disease prevention and health education, has been disrupted."

The same lament regarding preventive medicine comes repeatedly out of Britain, from both layman and professional man. It is the corollary to the proposition that the private physician is the keystone in the arch of the preventive or any other branch of medicine as applied to people in their daily lives.

BLUE SHIELD

THE plans of the American Medical Association for continuation of the National Education Campaign in 1950 call for increased emphasis on voluntary hospital and medical insurance. The prepayment method of providing for the expenses of unusual illness has been an outstanding success during the few years in which it has been in effect. Both commercial and nonprofit plans have grown at a most satisfactory rate, and now present one of the bulwarks against socialized medicine.

It is estimated that at the end of 1949, 66,000,000 individuals in the United States were protected by hospital insurance, and that of this number 40,000,000 individuals carried additional medical insurance for surgical and obstetrical services.

Mutual Medical Insurance, Inc., the Blue Shield plan for Indiana, has been one of the shining lights in the nation-wide development of voluntary medical insurance. This plan was sponsored by members of the Indiana State Medical Association, and enrolled its first member in September, 1946. When the company was only three years old it was ninth in size among all Blue Shield plans in the United States. During the first nine months of 1949 it enjoyed an increase in membership of 42.45 percent.

The third quarter of 1949 produced a 16 percent increase, and in this three-month period there were only two plans in the country, regardless of size, which enrolled more new members. In March 1950 Mutual Medical Insurance, Inc., had a membership in excess of 383,000, and at the present rate will soon be providing protection to 400,000.

While the growth of "The Doctors' Plan" has been prompt, its development has been orderly. It has been maintained on a sound financial basis, with adequate reserves, and with a low administrative cost. As actuarial data and experience have indicated, the benefits have been broadened, new types of coverage have been offered, and community enrollments have been conducted.

Additional protection has been offered to its members by the medical plan, which pays for inpatient hospital medical service not connected with surgical or obstetrical care.

Recently benefits were made available to a larger segment of the population by the offering of individual membership on a Health Statement Contract. This combined Blue Cross-Blue Shield certificate is offered to the self-employed, to retired persons, and to individuals (and their families) if they are employed by a firm with less than five employees.

Since individual membership has been available its acceptance has indicated that there is a genuine and widespread demand for this type of protection. Its growth has been steady, and almost all of the applications for this contract have been acceptable.

The evolutionary development of the various voluntary forms of medical and hospital insurance is a splendid example of the common-sense, feet-on-the-ground American way of solving difficulties. One can be critical of the British Health Scheme when it is stated that it could not have been established except by a sudden changeover and with autocratic controls. In contrast, here is the American plan for relieving the financial woes of medical care, which covers the bulk of the cost of catastrophic illness, at a price almost anyone can afford, and which is now available to most of the people.

The more people there are satisfied with voluntary medical insurance, the fewer there will be susceptible to the socialized medicine advocates.

President's Page

BATTER UP!

THE baseball season is here again. Ball parks are open and are crowded with fans screaming for hot dogs and home runs. Before the first play of every game a hush hangs suspended in the stands as all eyes are on the pitcher. The hush stretches through the windup and then breaks as the pitcher lets go. From the moment the ball leaves his hand, the game is on. But only for the fans—the public. For the players, the game is in full swing as soon as the pitcher picks up the ball. Their trained eyes focus on the windup, and their minds quickly calculate the curve of the ball and the point of the strike.

Baseball players and physicians have a lot in common. Where the ball player analyzes the windup, the doctor analyzes symptoms; where the ball player swings the bat, the doctor prescribes medicine and treatment; and where the ball player comes in for a home run, the doctor saves a life.

Right now the doctor finds himself at bat for his own life; he has been challenged by the standard-bearers of socialism. From his home-plate position, the doctor looks at the pitcher's mound and sees men like Oscar R. Ewing, the Welfare State's mouthpiece; J. Donald Kingsley, Ewing's former aide, Communist collaborator, and present Director General of the International Refugee Organization; and Harry N. Rosenfield, a D. P. Commissioner formerly in charge of "selling" the Wagner-Murray-Dingell bill to Congress. Others on the team include a few state and federal legislators, but for the most part they are men who hold appointive positions. The elected administrators who appoint them may be considered as team managers.

In order to avoid a one-two-three-strikes-you're-out destiny, it would seem that our only defense is to solve the pitching technique. Fortunately, we know that the opposition is counting heavily upon discrediting our professional work. We can shatter their hopes by rendering prompt, courteous, and effective service that is beyond criticism. Every big-league team consistently does its best for its fans; it has to, or it loses them. We cannot do less for our patients and expect them to back us in this political game. So remember, SERVICE will stop the opposition. No one wants to pitch to a home run king, and you, Doctor, are batter up!

E. S. Black,

Medical Panorama by the Associate Editor

TEACHING PUBLIC HEALTH AND PREVENTIVE MEDICINE TO MEDICAL STUDENTS

Under the above title, *The Journal of the Kansas Medical Society* publishes an interesting article prepared by E. V. Thiehoff, M. D., Professor of Public Health and Preventive Medicine, University of Kansas School of Medicine. He cites the strong spontaneous desire of the medical student to examine sick people and to try out his ability at diagnosis and treatment, and asks,

> Has the student during this process considered how this case could have been prevented? Has he considered what effect this illness has had on the patient's family or on their economic position in the community?

Doctor Thiehoff then presents his analysis of the problem and its solution as applied in Kansas:

> The private physician is the keystone of any preventive medical program. If the physician develops an awareness or "point of view" of prevention, and strives to the best of his ability to prevent ill health among the families who have chosen him as their physician, then he can truly be called a master of the art of medicine and a respected physician by everyone in the community.
>
> The undergraduate medical student, if given the chance and proper experience, readily recognizes the fact that the emotional, economic, and environmental features of illness are equally as important as the physical feature. An attempt is made to teach him that the four factors are so interwoven in the patient's subjective symptoms that not one can be considered separately to the exclusion of the others.

* * * *

> Arrangements have been made for senior students to serve a preceptorship for 11 weeks with general practitioners throughout the state in communities of 2,500 or less. The student will participate in the practice of the physician under whom he is serving. He will also have an opportunity to observe intimately the environment of many of the patients and to become familiar with some of the social and economic problems of both the physician and the patient.
>
> All in all, this department is attempting to train the medical student to take his place of leadership in all health matters in the community where he may practice as a private physician. This is a part of the "back to the grass roots movement" in Kansas, wherein the practicing physician will aid his community to plan their own health programs to meet local needs, problems and interests.

Hoosiers are always interested in "grass roots" points of view, whether political, agricultural or medical. It begins to look as if the old preceptor idea of our great-grandfathers had intrinsic merit and was not entirely just a frontier makeshift.

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327 YEARS AGO

The Plymouth Bay Colony originally tried a communal system, in which each person was to work according to his strength, ability and industry. There was a common storehouse and rationing. An editorial "letter" to the *Pittsburgh Medical Bulletin* notes the failure of this system and goes on to quote their Governor:

> "The colonists," writes Governor Bradford, who presided over them, "begane to thinke how they might raise as much corne as they could, and obtaine a beter crope than they had done, that they might not still thus languish in miserie. At length (1623), after much debate of things, the Gov. . . . gave way that they should set corne every man for his own perticuler, and in that regard trust to them selves. . . And so assigned to every family a parcell of land.
>
> "This had very good success; for it made all hands very industrious. . . . The women now wente willingly into the feild, and tooke their litle-ons with them to set corne, which before would aledg weakness, and inabilitie; . . .
>
> "The experience that was had in this commone course and condition, tried sundrie years, and that amongst godly and sober men, may well evince the vanitie of that conceite of Platos and other ancients, applauded by some of later times;—that the taking away of propertie, and bringing in communitie into a commone wealth, would make them happy and florishing; as if they were wiser than God. For this communitie . . was found to breed much confusion and discontent, and retard much imployment that would have been to their benefite and comforte."

Human nature hasn't changed, and some of us still like the form of government our colonial forefathers found best.

See Ecclesiastes, Chap. 1, verse 10.

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

ANIMAL RESEARCH HAS SAVED MILLIONS OF HUMAN LIVES

In New York, California, the District of Columbia and other places lawmakers are facing this issue: Should dogs be used for medical research?

The issue isn't new. It keeps bobbing up in states and cities all over America. But the odd thing is it is being kept alive by a very small but loud minority. A public opinion poll showed 85 percent of U. S. people believe dogs should be available to medical science.

The objectors protest that dogs subjected to medical experiments are "cruelly" treated. They decry the fact that some of these animals are "cut up" in surgical tests. And they argue that dogs aren't necessary to research.

What are the facts?

Millions of lives have been saved as a result of research performed on dogs and other animals. Diseases which once were mass killers—smallpox, diphtheria, lobar pneumonia, typhoid, syphilis and diabetes—today are largely under control because of animal experiment.

All serums, anti-toxins and vaccines were first worked out on animals. The discoverer of valuable streptomycin says its worth could not have been determined without tests on dogs. The U. S. Food and Drug Administration requires that all new drugs be thoroughly tried on animals before being applied to humans.

The search for cures for cancer, high blood pressure, polio and other dread diseases is absolutely dependent upon use of test animals. Dogs are particularly useful in cancer studies, for their physical and chemical make-up is in many ways close to that of humans.

Dogs employed in research are not pets but unwanted animals marked for death in public pounds. When experimenters get them, some die in the course of tests. But other dogs live on for a long time. All are given good care. Anesthetics are used wherever possible when surgery is called for, but naturally not every operation is painless.

It is estimated that medical research needs could be met if only about 1/25 of the unwanted dogs were turned over to schools and laboratories. Right now 29 of the nation's 78 medical institutions receive dogs and cats from community authorities. The other 49 have to patronize black markets to get the animals they need. Only two states, Wisconsin and Minnesota, have laws making unwanted dogs available for research.

At best the opponents of animal research may be described as sincere but misguided people. At worst they are irresponsible crackpots whose minds are cluttered with a wide assortment of phony notions about medical science. But whether sincere or not, all anti-vivisectionists are in fact the enemies of medical progress.

The only way to say it is that they are more concerned with saving dogs than they are with saving humans. Indeed, an eastern newspaper survey showed that four out of five anti-vivisectionists who were parents said they would not sacrifice a dog to save a child's life.

It's up to the overwhelming majority of Americans who wisely grasp the need for animal research to make sure that this strange but noisy minority does not have its way. Every medical school should be allowed the dogs it requires for vital studies. After all, humanity begins with human beings.

—*Terre Haute Star.*

BLUE CROSS ADVANTAGES

It is gratifying to see the progress that is being made in enrolling people in Blue Cross and Blue Shield medical and hospital protection programs, for this service can mean much to anyone needing health care.

Persons having this protection need not worry about hospital and doctor bills. Many hospitals honor the Blue Cross membership card and do not require advance payments.

Unlike the compulsory health insurance plan advocated by the Truman administration which would not permit a person to select his doctor, Blue Cross does not attempt to choose a doctor for its members. It lets the patient pick the physician he wants. Neither does it quarrel about the doctor's fee.

Many people think that plans like the Blue Cross are a more sensible and more reasonable solution to the problem of medical care than is the Truman program which would lead to socialized medicine. It is a great satisfaction for a man to know that his family is protected against sickness, and this can be accomplished in a safe and guaranteed way through the service that Blue Cross-Blue Shield offers.

Under Blue Cross, a person needing medical care or hospitalization may have 30 full days of care each year and 30 additional days at 50 percent, or a total of 60 days a year. Yet the average hospital stay is eight days. As a result many members of Blue Cross are admitted to hospitals several times each year and still do not use their full allotment.

—*Kokomo Tribune*

THE DOCTOR AND HIS COMMUNITY*

William H. Book

INDIANAPOLIS

The Author:

Mr. Book is executive vice-president of the Indianapolis Chamber of Commerce, and president of the American Chamber of Commerce Executives.

THIS afternoon I get the opportunity to tell you physicians how I think you can do a better job of cooperating with those who work for community improvement—your chambers of commerce. I have a conviction on the subject, and I shall try to state it in a friendly and frank way.

These are times that try the patience and the digestive apparatus of us all. While it may not be of the shooting variety, we are nevertheless in the midst of a very real war—a war for men's minds; a war that uses many of the hateful techniques of its very near relative. No one who cherishes his birthright of liberty and freedom—freedom to use talents and skills, and the initiative born in him, to the most productive and useful purposes —can be complacent in the presence of this worldwide attack.

There is a perspective about this war, very important to the defenders of individual freedom. Two points stand out. One, the danger of internal subjection by Moscow-directed communism, is not so great now as it has been. Two, the greatest threat to our heritage is from the advance of socialism in our country, often masked, creeping, indirect, but a steady advance, nevertheless.

A C.I.O. friend recently argued with me on the first point. He felt I was wrong in seeming to minimize the danger to our country from Russia's fifth column. I could well understand his anxiety, and his desire to see others just as anxious as himself. My stage of extreme anxiety over this threat occurred some years earlier. The C.I.O., however, is as yet only in the early stages of its own exposure and liquidation of communist infiltration. National and local unions are still engaged in their purge of the communists within their ranks. Further battles are yet to be fought before some of these groups can cleanse themselves thoroughly of this infection. The leaders of this battle need the sympathy and friendly support of all of us.

Yet I am encouraged by the developments of the past four years. Communist infiltration of our schools, our churches, our labor unions, even our government, is no longer looked upon with complacency. It is no longer smart to be a communist, or to be friends with communists, in low circles or high. The disclosure of the Canadian spy ring; the forthright manner in which the Canadian government met the menace—it was no red herring in Ottawa; the amazing, fantastic stories of Elizabeth Bentley and Whittaker Chambers; the trial of the eleven top Communists for conspiracy to overthrow our form of government by violence; the conviction of Alger Hiss; the loyalty tests within our government, even if they may have seemed less than enthusiastic—all these certainly demonstrate that at last we are awake to this particular internal peril.

It would be foolish, of course, to underestimate the cunning, the cupidity, the completely unprincipled character of these psychopaths. They will change tactics and fronts with every change of the wind. They seem to have made life a little miserable for some of those who thought of them only a few years ago as our brave allies. Now I am convinced that at last our country is pretty much awake. No longer need we fear so greatly that high officials of our government, our labor unions, or our other institutions will either condone or hide these people in places of responsibility.

The awakening of leaders and the public alike has put a great weapon in our hands. That is the weapon of exposure. Very obviously most communist conspirators now fear nothing worse than that they be exposed in their nefarious conspiracies. Can one explain in any other way the procession of suspected communists who stand on their constitutional rights and refuse to answer the simple question "Are you a member of the communist party?" Let the people know—the truth come out, and these insidious, evil enemies of freedom lose their worst threat to us.

So it is not of them that we need to be worried principally today. Let those who are just waking up to the danger at long last have the privilege of finally driving these enemies from all positions of power.

But the second danger is the one which I fear the most, the creeping spread of socialism in our country. Our greatest threat even today still arises from our unwillingness, as in the case of the Communists four years ago, to face the facts and believe the truth. We are still living in a fool's paradise, believing it cannot happen to us. It is probably somewhat like carrying coals to Newcastle to enlarge upon that point with this audience. Yet it is important for us in this day, particularly, to know exactly what we are talking

* Presented at the National Conference on Medical Service, in Chicago, on February 5, 1950.

about. For you can be very sure the politicians will use all their skill and dexterity to avoid sharp definitions, to becloud the issue, to confuse the public mind.

Do we not have it on very high authority that socialized medicine is not socialism? I hear a distinguished lawyer, who has become expert overnight in the field of economics and medicine and other sciences, extol the virtues of socialized medicine in England and then a very short while later attempt to assure us he has nothing like that system in mind for us. Certainly he won't call it Socialism. He will try to give it a very different dress.

If you have read John T. Flynn's book, "The Road Ahead,"—and you ought to—you will gain a clear insight into the manner of this creeping paralysis. You will clearly understand that Socialism would never have advanced in England had not the great Liberal party and even the Conservatives begun to espouse some of its goals; that this same course is in store for our country.

Do you imagine that the Socialist party of my fellow Hoosier, Eugene V. Debs, or those who admit to being Socialists today, would ever have had a chance with the voters of our country? I imagine some of these avowed Socialist leaders today must be having a mixture of gratitude that their pet schemes are being adopted. But they must also be as astonished as the small boy who has just had his ice cream cone lifted out of his hand by the neighborhood bully.

No, this America of ours—this land of liberty—with its heritage of greatness established on the sacrifice, the ingenuity, the skill, the energy, the inventiveness of a people determined to give full sway to individual initiative, this land of ours would not even today vote for socialism, or any form of it, if it were properly labeled on the ballot. Let the issue be drawn squarely and plainly, and they will even yet turn away the threat.

It will be interesting and revealing to note how many candidates for Congress this spring and fall will go to the voters saying openly, "I am for socialized medicine." Rather, I should say, how few. In some cases, perhaps, they will belabor the argument that National Health Insurance is not socialized medicine. But I am more certain the great majority of the candidates, if they have any leanings toward this system, will neatly duck the issue, hoping the voters will miss the point of what they really believe.

I am not, of course, advocating the idea, that those of us who so ardently believe in free enterprise, against socialism, should try to label everyone who has different views from us as either communists or socialists. There is a danger of wrongly charging a man, and arousing public sympathy for him and his movement. I am no economist, no student of Marxism, or Fabian Socialism. In my own awkward way, however, I think I recognize socialism and socialists when I see it and them.

I heard a Socialist argue that public schools are socialism, and since we don't oppose public schools, maybe Socialism isn't so bad. That doesn't confuse me one bit. The man who argues that socialism depends wholly on government ownership of the title of industry and business likewise does not confuse me in my simple thinking. For it seems to me it is socialism if my government takes from me, a citizen, excessive amounts of my income in the one case, and uses the fruit of my effort for schemes which pauperize and destroy incentive and initiative in other individuals.

To be specific, national health insurance is socialistic to me, because it will require a further excessive tax added to an already extortionate tax, to be used to make millions of Americans believe they do not have to work to supply their own needs.

Social security need not be socialism, if it were real insurance, on the actuarial insurance principle of each one taking out in proportion to what he puts into the insurance pool. But when we propose to enlarge the system so that quadruple payroll taxes will not even be enough to pay greater benefits to millions who will not have earned them, then it becomes socialism to me.

So when I hear anyone argue for the equal share to all, as in England, or for new schemes that will make government bigger, increase its hold upon our daily lives, destroy individual incentive to produce, I confidently call it socialism, and know it can end, as all the history of the world, ancient and modern, has so often proved, in producing less than we need, in requiring price controls, wage controls, controls over where a man works, and eventually concentration camps and dictatorship as the inevitable result.

I have taken some time to expound this belief for a reason. The private physicians of this country are today facing the greatest threat that ever has confronted free medical practice in our land.

They may be feeling rather alone in their battle. It is the strategy of every radical movement of history to divide and conquer. A whole body politic is too large an order for most incipient dictators of other men's lives. So they attack small segments at a time.

Business men have been in the doghouse for lo, these many years. Before the days of the New Deal, it was popular to advocate public ownership of the power generating and distributing industry. The spread of socialism through government ownership in that field started long enough ago that the beginning seems dim to me. Had not private management done such an outstanding job when the railroads were returned to their control after World War I, I have no doubt the railroads of our country would have been nationalized long ago.

Now the first great professional group is under attack. If that attack succeeds, certainly other professional groups will be attacked also in the struggle of power-mad men to gain control over the lives of all citizens.

I often hear business men today say among themselves—much as they abhor socialized medicine—"Well, it's too bad, but the doctors have had it coming to them." I am as horrified by such a statement as you would be. For men who utter such a thought are surely of very short memory and dull perception. That kind of thinking comes from men who perhaps have been just as irritated over the shortage of hospital beds and of doctors in these past four years as over the other great shortages that have quite naturally plagued us coming out of a total war. It comes from men who have not been taking the time and the effort to keep themselves informed. They have, like most of us, suffered from the psychosis of post-war frustration. And some of our newspapers and magazines, with their "play to the galleries," appealing to the most selfish motives of people, have contributed their part of the national malaise.

When I hear such a criticism, I feel called to do some very plain talking, for of all times, there never was such an urgent need that all who oppose socialism close their ranks and fight in unison. The very strategy of divide and conquer works only when people are unintelligent and uninformed. So there never was a greater need for unity between the doctors and all others in this country who recognize the dangers of socialism, and wish to strike telling blows for its defeat.

I think, also, there is a constant need for intelligent self-analysis. I have absolutely no doubt that business men have contributed to the advancement of socialism by some of their own efforts. It is still all too often a common sight to witness business men, individually, or in a group —maybe even a representative of a chamber of commerce—waiting hat in hand upon a government bureau or a congressional committee, with a deviously rationalized plea for some of that government pap.

I often wonder, as a layman, whether the doctors, sometimes in spite of their deep conviction against socialized medicine, may not be helping to promote it. I think of a city, for example, where there is great need for an additional hospital facility, for pay patients. It would be a difficult task, I am sure, to raise the millions that would be required to build even a half-way adequate hospital. Yet I am very sure in my own mind that the creeping spread of socialism will be aided if that community takes the easy course of calling upon its local and federal government to build that hospital out of public funds.

How much better for the business men and the doctors of that community if they would face up to the problem, and organize to raise the money for this enterprise from private subscription and donation, just as they do for their Community Chest! The community can far better afford to pay for its own, in this way, leaving the hospital in the hands of competent medical men to administer, than to have the local public officials build it and then place it under political management.

But my most urgent plea to you today is for understanding between business and civic leaders, and your own profession. I am sure I am not exaggerating when I say that the proportion of doctors who take any part whatsoever in civic problems of a community is pretty low. Even considering their total number in relation to the total number of manufacturers, or merchants, or other business segments, it is not so good. But doctors as a group are better educated—yes, I think they are more intelligent—than any other single group of citizens. Yet, as a man who has spent over twenty-five years working with men engaged in causes for community betterment, I am compelled to say that I rate the IQ of doctors on such questions pretty low.

Let me cite a few particulars. Apply them to yourselves and then judge how far right or wrong I am in your case. How many of you were concerned enough with this creeping paralysis of socialism that you voiced your views to your Senators or Congressmen when the public housing bill was being passed at the last session of Congress? How many of you are acquainted with the issues and have stated firm convictions on the important subject of federal aid and control of the public educational system? How well are you prepared to discuss and take a position on such vital matters as extension of more Valley authorities, such as the TVA, the Brannan farm plan, labor management relations under the Taft-Hartley Act, fair employment practices, and extension of social security programs?

I would quickly agree that the average doctor has been so busy these past ten years he had little time or energy to spend on such matters. Well, he has come now to the point where he had better find the time and energy. The appalling need for unity among those who oppose socialism is so great that without it the war can be lost. I am not talking in generalities. I am trying to be very specific.

For example, I know of a community where the membership of a prominent service club was checked to see what proportion of the membership voted in the last general election—the election of 1948, when we lost a battle, if not the war, against socialism. That particular club had a pretty good record—all but the doctor members.

I am, because of my office, in pretty close contact with chambers of commerce throughout the country. The doctor, like any other business man, gains much direct benefit from the business-building

activities of a chamber of commerce. He won't have patients if they are not there; they can't pay their bills unless they are gainfully employed; the doctor's investment of his earnings in real estate or business enterprises is protected just as much as the manufacturers' by the efforts of this collective group of citizens working as a chamber of commerce. Notwithstanding these facts I relate, the proportion of doctor members of 95 percent of the chambers of commerce of this country is far below that of any other group of business or professional people.

There are some notable exceptions. I recently read a letter written by a prominent physician of a midwestern city to every fellow physician of his community. Let me quote a sentence or two:

> "The first obligation on the physician's list after he has paid his professional dues should be his membership in the Chamber of Commerce. Of course this is not compulsory; we could all practice in this city and reap our share of the business brought here by this organization and still not help to support it. That, however, is like receiving police and fire protection without helping to support these departments; like accepting the educational facilities without helping support the schools; and like receiving the advantages of our fine moral enivronment without helping support the churches.
>
> "No thinking physician would want to live in a city of this size without a Chamber of Commerce. Every physician profits many, many times over the cost of the membership. So, not only is it a civic duty to support this efficient organization, but it is good business as well. No physician should have to be sold a membership, he should want to buy one."

And in that community the great majority of the doctors are members of that fine organization.

When I read that doctor's statement my mind turned to just a few of the many ways in which doctors can help their communities through service in their chambers of commerce—on public health committees, for example, to promote consolidated and improved public health administration; on local taxation committees, to work for more efficient, less costly local government; on national legislation committees, to present a united front against the spread of socialism not only through socialized medicine, but through federal aid to education, public housing, protection of vast labor monopolies.

I am making no selfish appeal to you. The chambers of commerce will continue as active, important agencies for community building, and, now more important, for protection against the creeping spread of socialism. They have gotten along, many of them, with little or no physician participation for a good many years.

But that is no proper answer for you to make, or for me to make. I said at the start of this discussion that we are engaged in a very real war, a war for men's minds. It will take all the effort in public education that can be mobilized to win this war. There is no single group doing more at the grass roots level to protect our country against socialized medicine than the organized doctors. There is no single group doing more to educate and to lead against socialism in *all* its forms than the average chamber of commerce. Some of them are very much in the vanguard of this battle. I know of one which last year presented the dramatic story of the success of free enterprise, the failure of socialism, with authentic, top-grade motion pictures and talks before 1,189 groups of people, over 170,000 in all, in its own community.

Throughout this land there is a great stirring. Hundreds and thousands more are joining the battle every day. Cynicism and despair are giving way to the determination to give battle; to go down fighting, if need be, but to fight. And such a spirit gives the first promise of victory in the war. The country is becoming aroused. The danger is being pointed out. The issue is being defined. It is time for all of us who believe in free enterprise, who abhor the socialist state, to close ranks and give battle. There is sure victory ahead for us in this war to prevent socialism from capturing men's minds, if we do. As soldiers in the battle, let us stand shoulder to shoulder, striking the enemy wherever he appears. We shall preserve the heritage our fathers handed down to us no other way.

FAMOUS PHYSICIAN TO EDIT FAMILY DOCTOR JOURNAL

Dr. Walter Alvarez, senior consultant in the Division of Medicine in the Mayo Clinic, has been appointed medical editor of *GP*, published by the American Academy of General Practice.

The first issue of the new journal was mailed the first week in April.

Doctor Alvarez was selected to succeed Dr. F. Kenneth Albrecht, who died following an automobile accident last month.

Doctor Alvarez has served as editor on both *The American Journal of Digestive Diseases* and *Gastroenterology*. He has been contributing author to several important books and has more than 650 articles in the medical literature throughout the country.

Having reached the age of retirement at the Mayo Foundation, he is moving his residence to Chicago where he will assume the duties of medical editor of *GP*.

The appointment of the new editor from among several outstanding candidates was made following a meeting of the Academy's Publication Committee, of which Dr. Arthur N. Jay, of Indianapolis, is a member.

THE NATIONAL BLOOD PROGRAM OF THE AMERICAN RED CROSS*

G. Foard McGinnes, M.D., F.A.P.H.A., Ross T. McIntire, M.D., and George W. Hervey, Sc.D.

Vice President for Health Services, American National Red Cross; Director, National Blood Program; and Chief of Biostatistics, National Blood Program, Washington, D. C.

COMPLETION of the first seventeen months of operation of the National Blood Program suggests that an appropriate time has arrived to review for the members of the American Public Health Association some of the more salient facts concerning the genesis, development, and present status of this large-scale undertaking by the American Red Cross.

During the war 13,326,242 pints of blood were obtained from voluntary donors by the Red Cross. Of this huge quantity, 12,628,645 pints were processed into dried plasma and serum albumin for use overseas, 310,135 pints were delivered for use as whole blood or liquid plasma at military hospitals in the United States, and 387,462 pints of group "O" whole blood were flown overseas.

Even before the end of the war the accomplishments of the Red Cross in procuring blood for the armed services resulted in a demand that the agency institute a similar service for the benefit of the civilian population.

In April, 1945, the governing body of the American Red Cross voted that chapters desiring to do so might participate in a civilian blood donor service sponsored by a qualified medical or health agency, but limited their activity to the recruitment and enrollment of volunteer donors and to the provision of non-technical staff and equipment.

These so-called "permissive programs," functioning independently of each other, have never been organized along the cohesive and uniform lines essential to the operation of a national blood program.

The slowness with which the Red Cross civilian blood donor services were developing under the permissive arrangement, and the likelihood of an eventual shortage of plasma, serum albumin, and immune serum globulin, resulted in a formal recommendation (February, 1947) by the executive committee of the Red Cross Advisory Board on Health Services to the effect that the organization proceed as rapidly as possible to the establishment of a national blood program. In June, 1947, the governing body of the Red Cross endorsed that recommendation and expressed the belief that "there is need for such a program, that the American Red Cross should undertake the responsibility for it, that sufficient blood can be collected from voluntary donors, and that the necessary funds can be raised."

Under its established policy the American National Red Cross refrains from instituting a regional center or program unless specifically requested to do so by the chapters concerned. The application from the chapters must be approved by the county medical society, local health department, and local hospital association covering each community of the region under consideration.

In the operation of the program the highest professional and technical standards are maintained. To that end, outstanding experts in the field of blood and blood derivatives collaborated in setting up the technical procedures, which are uniform for all centers. On the national headquarters staff in Washington, D.C., Dr. Louis K. Diamond is the Medical Director of the entire program. At each regional center the technical supervision is similarly vested in a medical director. The chapter engages the services of a center director who is responsible for non-medical administration. Locally, a medical advisory committee stands ready to give professional counsel.

In the smaller communities, visited periodically by mobile units from the regional centers, the blood collecting procedures are identical with those at the centers. Mobile units are sent also to large industrial concerns during working hours. Both inside and outside of the regional center cities, the National Blood Program staffs of the area headquarters of the Red Cross function as advisers to the staffs of the centers, who, in turn, assist the outlying chapters in the extension of the program to the communities within their jurisdictions.

Experience has indicated that five pints of blood annually for each bed in general hospitals and one pint for each bed in the other hospitals are probably reasonable allowances for current needs, which means 3,700,000 pints of blood annually. In announcing that the American Red Cross would undertake to help supply that quantity, President O'Connor stated that the Red Cross would make no charge for the blood and blood

* Excerpts from an article which appeared in American Journal of Public Health, Vol. 39, No. 11, November 1949.

derivatives it provides to physicians and hospitals for the treatment of their patients. The only charges to recipients are those made by the physician or hospital in connection with the administration of the products. Under this arrangement, blood and blood derivatives are made available not only to civilian hospitals but to military and veterans' hospitals as well.

Between January 12, 1948, and the end of May, 1949, the American Red Cross made available 242,782 pints of blood for the use of physicians in the communities served by the national program. That quantity was contributed by 207,183 persons, 17.8 per cent of whom were sufficiently interested to donate a second or third time. In addition, 29,955 persons were rejected, chiefly for medical reasons, and 3,114 were unable to contribute a sufficient quantity for them to be counted as productive donors. On bringing these figures together, it is found that 240,252 persons actually presented themselves as possible donors.

In the initial 17 month period whole blood was distributed to 1,050 hospitals, 137 physicians, and 46 independent clinics; and 816 communities were visited by mobile units in accordance with schedules arranged many weeks beforehand. Approximately 67 per cent of the total quantity of blood collected was used in communities within the regional center city chapter jurisdictions while the blood donations therein constituted 55 per cent of all donations. The difference between these proportions is believed to reflect a considerable urban hospital demand for blood for patients from the outlying communities.

The comprehensive character of the Red Cross organization and the maintenance of complete records at the centers render the program a potential instrument not only for supplying the usual peacetime regional needs for blood but also for saving lives in the event of a major disaster. Complete information as to the blood group of the individual donor, the Rh factor, his address, and certain pertinent medical history data are all entered on a registration card. The cards are filed alphabetically; hence, whenever the call may come the Red Cross will be in position to refer to the names and addresses of potential donors and to know the total supply and location of the blood available.

In addition to the collection of whole blood to meet current needs for transfusion purposes, there is an important collateral phase of the National Blood Program that should be reported. During the first eleven months of the fiscal year 1948-1949 the American Red Cross issued for medical use 590,332 vials (2 ml.) of immune serum globulin; 10,931 vials (100 ml.) of serum albumin; 3,106 vials (20 ml.) of serum albumin; 374,883 units (250 ml.) of dried plasma; and 1,666 vials (5 ml.) of anti-hemophilic globulin.

From the preceding paragraphs it is evident that the American Red Cross, by responding to the request that developed from a successful wartime experience, has embarked upon a humanitarian enterprise that will offer better protection against the suffering caused by disease and injury. To insure that protection the National Blood Program will need the support of thousands of citizens through their contributions of blood, and the continued interest of members of the medical profession. On completion of the first 17 months of operation, there is already in the record evidence of a fine cooperation that promises even better success for the program in the years ahead.

PUBLIC HEALTH SERVICE 1949 REPORT

A HALF CENTURY of public health progress in lifesaving and disease control gives great hope of success in curbing the chief killing and disabling conditions of the century, according to the 1949 report of the Public Health Service, recently made public by the Federal Security Administrator.

The advances which have brought about better health and longer life, Surgeon General Leonard A. Scheele points out in the report, results from the application of scientific findings to the health care of the people, from more health services and hospitals, and from wider use of the services available. As a byproduct of this progress, however, different and continually changing health problems have arisen. Among these, the chronic diseases are the most outstanding.

Quoting from the vital statistics record, the most reliable measure of the nation's health progress and problems, the report states that 3.7 million babies were born in the calendar year 1948, the next largest number the nation has ever produced in one year. The general death rate was the lowest on record—9.9 per 1,000 population.

The constant decline in the death rate over the past fifty years can be attributed to the reduction in deaths from communicable diseases. Striking reductions, for example, are still being recorded in death rates from pneumonia and influenza and from tuberculosis. These diseases were the leading causes of death at the turn of the century. Today they are sixth and seventh respectively. Since 1940 the pneumonia-influenza death rate has declined by 46 percent (38 per 100,000 population in 1948). The tuberculosis death rate in 1948 was the lowest on record—30 per 100,000 population.

Infant mortality in the United States reached a new low in 1948—31.8 deaths per 1,000 live births. Although infant mortality has been cut by more than two-thirds in the last thirty years, the savings have been chiefly among full term babies after the first month. Premature birth is still among the ten leading causes of death.

As a result of the success which has been achieved

in prolonging life, the average life expectancy of a child born today is 67 years. More than a quarter of the population now is 45 years of age or older, and ten years hence one-third of all Americans will be in the middle and older age brackets. This aging population places emphasis on the changing picture of health and highlights the areas in which public health must strengthen its efforts. Heart disease, cancer, and cerebral hemorrhage are the three leading causes of death in the United States. Deaths from these causes are concentrated chiefly in the older age groups. Deaths from heart disease and cancer have increased enormously and steadily since the turn of the century, and these two causes alone now account for nearly one-half of all deaths. Mental disease, probably, is the country's leading cause of ill health and disability.

Doctor Scheele pointed out that over the years in which the chronic diseases, accidents and mental disease have been on the increase, the physical environment has been changing rapidly. Today, housing conditions in many parts of the country are causing much mental and physical ill health. Cities and industries produce enormous quantities of waste that pollute the air, the streams and the rivers. World health grows constantly in importance as nations come together more closely through rapid travel.

LETTER TO THE EDITOR

In his "Letter to the Editor" in the February, 1950, issue of this Journal we detect signs in a paragraph on radiation treatment of toxic goiter that our good friend, Dr. Goethe Link, wrote this particular section "with tongue in cheek" and a gleam in his eye in anticipation of reactions to come.

It might well be said that the radiologist whose therapy schedule includes even a moderate number of thyrotoxicosis patients, with their typical psychological difficulties and extreme nervousness, is receiving cruel and unusual punishment, although reports accumulating in the literature indicate that radioactive iodine may well lighten this load by offering a method of treatment superior to the older techniques as regards both the overall length of treatment time required and the final results.[1, 2] Lack of some of the facilities required for employment of artificially radioactivated substances has so far prevented use of radioactive iodine in this locality but excellent results are being reported with conservative dosage.

However, it should be noted for the record that both x-ray and radium therapy methods have long been affording relief from thyrotoxicosis, and cures as judged by the usually accepted criteria. This has not been merely our own experience.[3] It has seemed doubtful to us personally, however, that in the majority of cases treatment by x-ray or radium should be the preferred method, especially in the acute types, although the latter will often do quite well with such management. Nevertheless the patient who is uncontrollably nervous, or who has postoperative recurrence, or who on account of much heart damage presents grave risks with surgery, has a recourse here which can effect many cures and also greatly relieve the physician who is in charge. In the intermediate range between these types there may well be room for debate as to choice of methods.

We would go even further than does Doctor Link and reduce his estimated x-ray dosage from 1500 roentgens to 700-750 roentgens of high voltage x-ray per series of treatments fractionated over a period of three to four weeks total duration to obtain greater effectiveness upon the thyroid, and at the same time make for better skin tolerance. In no case need the dosage be sufficient actually to destroy gland tissue in the sense of producing necrosis. Response to externally applied radium we have observed in various instances to be more rapid than with x-ray, at times even spectacular, but there seem to be no comparative statistics upon this point.

It is probably correct to say that relatively few radiologists are anxious to take on the worries incurred in x-ray therapy of the usually very trying thyrotoxicosis patients, but the happy experience of seeing numerous such individuals restored from a critical condition to a quite passable state of health by irradiation makes us feel that there is here a broad field in which radiology can be of at least cooperative service. If not, the status of such cases as have postoperative recurrence or severe cardiac damage would be tragic indeed.

It might be added parenthetically that some recent limited experience has shown radiotherapy to be extremely helpful to some patients resistant to preoperative management with thiouracil compounds, apparently giving great assistance in preparing these for operation.

Although thyrotoxicosis is only a part of a general functional disturbance, from the scientific and therapeutic standpoints we would like to see further earnest efforts at investigation of the advantages which we believe can accrue from cooperation in this field. If the subject has indeed previously been considered closed, the introduction of the thiouracil compounds and of radioactive iodine poses new possibilities in any event.

Lester A. Smith, M.D.

1 Soley, M. H., and Stone, R. S., Arch. Int. Med., 1942, 70:1002.

2. Soley, M. H., Miller, E. R., and Foreman, N. J., Clin. Endocrinol., 1949, 9:29.

3 Kaplan, I., Year-Book of Radiology, 1943, p. 365, Year-Book Pub. Co., Chicago.

THE CARE OF HAND INJURIES*

Lacerated Wounds

I. *Protection of the Hand* (Abstract of Article I)

The first-aid care of wounds of the hand is directed fundamentally at protection. It should provide protection from infection, from added injury, and from future disability and deformity. The best first-aid management consists in the application of a sterile protective dressing, a firm compression bandage and immobilization by splinting in the position of function (wrist hyperextended in cock-up position; fingers in mid-flexion and separated; thumb abducted and in midflexion, with tip pointing toward little finger). No attempt should be made to examine, cleanse, or treat the wound until operating room facilities are available.

II. *Requirements of Early Definitive Treatment* (Abstract of Article II)

Early definitive care requires thorough evaluation of the injury with respect to its cause, time of occurrence, status as regards infection, nature of first-aid treatment and appraisal of structural damage. For undertaking the definitive treatment the conditions required are a well-equipped operating room, good lighting, adequate instruments, sufficient assistance, complete anesthesia, and a bloodless field. Treatment itself consists of aseptic cleansing of the wound, removal of devitalized tissue and foreign material (exercising strict conservation of all viable tissue), complete hemostasis, and the repair of injured structures, to be followed by protective dressing to maintain the optimum position. After-treatment consists of protection, rest and elevation during healing, and early restoration of function by directed active motion.

III. *Surface Injuries* (Previously circulated)

IV. *Lacerated Wounds*

Lacerations may damage skin, fat, fascia, muscles, tendons, tendon sheaths, blood vessels, nerves and, more rarely, joint or bone. The treatment of such injuries has four objectives:

1. Protection from infection.
2. Restoration of structures.
3. Avoidance of deformity.
4. Early restoration of function.

These objectives are furthered by proper first-aid care, as outlined in I (*Protection of the Hand*) and by definitive treatment.

A. Definitive Treatment

To be undertaken only under the proper conditions and according to the principles outlined in II (*Requirements of Early Definitive Treatment*). Careful history of the injury should be followed by examination of the hand to determine:

(1) Location and extent of the wound.
(2) Source of major bleeding.
(3) Presence of foreign material.
(4) Function of tendons, to be tested *against resistance*.
(5) Function of intrinsic muscles.
(6) Condition of nerves as regards both sensory and motor functions.
(7) Integrity of bone and joint.

Following anesthetization of the patient and application of hemostatic blood pressure cuff (not to be inflated above 300 mm), definitive treatment of the wound consists of:

(1) Thorough cleansing of wound region and then of entire hand and forearm with soap and water or bland detergent.
(2) Removal of foreign material from the wound.
(3) Careful, gentle, thorough, but conservative excision of devitalized tissues, sparing all structures that may survive.
(4) Repeated cleansing of wound by irrigation with warm normal saline solution.
(5) Securing and ligation of divided blood vessels.

These general measures are followed in appropriate cases by repair of damaged structures. Proper wounds for this repair are:

(1) Those in which infection has not become established.
(2) Those not grossly contaminated by highly infective material.
(3) Relatively clean wounds not more than three or four hours old.

In general, wounds not fulfilling these criteria are better left unrepaired to await secondary closure and later reconstructive surgery. They should, nevertheless, be as carefully cleansed of foreign matter and dead tissue as are those prepared for primary closure. In such cases severed nerve ends may be identified with nonabsorbable sutures or lightly united.

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*Note: This is the fourth and last of a series of articles on The Care of Hand Injuries. This material is prepared by the American Society for Surgery of the Hand and is distributed by the Committee on Trauma, American College of Surgeons, through its Regional Committees.

Repair of damaged structures:

(1) Nerves

a. All severed nerves should be repaired, including the digital nerves.

b. Fine arterial silk on fine needles should be used, accurately approximating the nerve ends by small interrupted sutures placed around the periphery. These sutures should include only the perineurium, not the nerve bundles. It is important to avoid axial rotation, particularly in nerves having both motor and sensory function.

c. Nerves are to be distinguished from tendons, especially at the wrist, by their anatomical position, softer texture, pinker color, small surface capillaries, and distinct nerve bundles seen on cut ends. Pulling on a nerve will not flex a finger.

d. Nerves should be handled gently, never crushed, rubbed, or allowed to become dry.

(2) Tendons

a. All severed tendons should be repaired, including the tendons of intrinsic muscles.

An important exception to this rule concerns flexor tendons severed within the flexor sheath or in the digital flexor canal. Primary suturing of the flexor profundus in this location rarely succeeds in restoring useful function even if the flexor sublimis is removed. Suturing both flexor sublimis and profundus in this area almost invariably results in failure. Should even minor infection occur, failure is assured. With rare exceptions, it is sound practice to repair the skin and digital nerves only, leaving the flexor tendons for secondary reconstruction when severed in this region.

b. Nonabsorbable sutures of silk or wire are used accurately to approximate the severed tendon ends after they have been cleanly squared off with a sharp knife.

c. Additional incisions to secure retracted tendon ends should follow flexion creases. They should be curved or transverse, never longitudinal, and never in the palmar or dorsal midline of a finger.

d. Tendons should be handled gently; never crushed, rubbed, or allowed to become dry.

(3) Muscle

a. Severed muscles should be lightly approximated with interrupted mattress sutures, avoiding tension and constriction.

b. Muscle thus repaired should be alive, contractile and vascular, all devitalized shreds being trimmed away.

Following these procedures, the hemostatic blood pressure cuff is released to permit identification, control and ligation of bleeding vessels. The field should be dry before closure of the wound.

(4) Fascia

Severed fascial and ligamentous tissue should be repaired with interrupted mattress sutures, avoiding tension.

(5) Subcutaneous tissue

Subcutaneous fatty tissue may be lightly approximated with interrupted fine sutures.

(6) Skin

The skin should be closed with fine, nonabsorbable sutures.

(7) Dressing

Firm pressure dressing is applied, the fingers being separated, with gauze between them. The hand is immobilized by splinting in the position of function, except when suture of severed tendons requires splinting in a position to insure the least strain on their suture lines. If nerves have been severed, the position of function is particularly important to prevent deformity due to contracture of active muscles when their opponents are denervated and paralyzed.

B. Aftercare

(1) Antibiotics and tetanus antitoxin (or toxoid) are administered systemically as prophylaxis against infection.

(2) The extremity is kept elevated for the first three or four days.

(3) Dressings are not removed for several days, usually one week, unless infection develops.

(4) The healing of severed tendons and nerves requires three weeks of uninterrupted immobilization.

(5) When nerves are severed, corrective splinting is necessary until reinnervation of paralyzed muscles has occurred.

(6) Restoration of function is best secured, after healing, by directed voluntary exercise and appropriate occupational therapy.

Committee on Industrial Health
Indiana State Medical Association

News Notes

SEMINAR IN ANESTHESIOLOGY

A seminar in anesthesiology will be conducted on May 17 at Indiana University Medical Center. It is jointly sponsored by the School of Medicine and the Indiana State Society of Anesthesiologists. All physicians in Indiana are invited and urged to attend.

Clinics will be conducted from 8:30 until 10:45 in the morning, followed by two papers. Dr. Harris B. Shumacker, Jr., will discuss "The Role of the Anesthesiologists in Cardiac and Chest Surgery." Dr. Richard Theye will discuss "Clinical Evaluation of 3 Spirothiobarbiturates for Intravenous Anesthesia."

A round table discussion will be held during the lunch period at the Riley Hospital.

The afternoon program will consist of four papers as follows: "Application of Electroencephalography in Anesthesiology," by Dr. Albert Faulconer, the Mayo Clinic; "The Role of Anesthesia in Therapy," by Dr. Jacob J. Jacoby of Columbus, Ohio; "Signs and Symptoms of Anesthesia," by Dr. Ivan B. Taylor of Wayne University School of Medicine; and "Some Pitfalls in Clinical Anesthesia," by Dr. William A. Friend of Akron, Ohio.

SEVENTH NATIONAL CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS, SAN FRANCISCO, JUNE 25, 1950

All physicians are invited to attend. County Medical Society Officers are especially urged to attend.

The Program

The program for June is designed as a discussion forum on subjects of particular interest to county medical society officers.

The Method

Speakers will open up the discussion on each subject, but all persons attending the Conference will be welcome to participate in the discussion.

The Time

The Conference is scheduled for Sunday, June 25—the day prior to the opening session of the House of Delegates—from 9:00 a. m. to 12:00 noon for the Morning Session, and from 8:00 p. m. to 9:30 p. m. for the Evening Session.

The Place

Palace Hotel—San Francisco.

This is *Your Meeting.* It is sponsored by the *Board of Trustees,* and is designed to *Help Your Society.*

ATTEND THIS GRASS ROOTS CONFERENCE
Learn How Others Do It!
Tell Others How You Do It!

SYMPOSIUM ON POLIOMYELITIS

There will be a Symposium on Poliomyelitis at the Indiana University School of Medicine, at Indianapolis, on June 7. The morning session, under the chairmanship of Dr. L. T. Meiks, of Indianapolis, will be devoted to poliomyelitis, the medical disease; incidence, epidemiology, diagnosis, symptomatic care, handling of contacts, care in the home of mild and moderate cases, signs of early oxygen deficit, indications for emergency tracheotomy in polio, public health problems in the community. The afternoon session will be under the chairmanship of Dr. George J. Garceau, of Indianapolis, and will deal with poliomyelitis, the orthopedic disease; the mechanics of polio care, splinting versus nonsplinting, use of hot packs in muscle spasm, evaluation of muscle involvement; basic physiotherapy and its use in home care; end results and the reconstructive program. More complete information will be carried in the June issue of THE JOURNAL.

TUMOR SEMINAR

The Billings Veterans Administration Hospital, together with the Indiana Association of Pathologists, will hold a Tumor Seminar at Billings in Indianapolis, Sunday, May 21. Dr. Granville A. Bennett, head of the department of pathology of the University of Illinois College of Medicine, will be moderator of the seminar which will be devoted to Bone and Joint Pathology. The Billings Hospital group invites those interested, including residents and interns, to attend.

A.M.A. GOLF TOURNAMENT MONDAY, JUNE 26

C. E. Shannon, M.D., Chicago, President of the American Medical Golfing Association, announces that the 34th Tournament will be held on the two very attractive golf courses of the Olympic Golf Club, San Francisco, on Monday, June 26, on the opening day of the 1950 A.M.A. Annual Session.

Fellows planning to participate should send, as soon as possible, their name, handicap, and section in medicine in which they will register to Secretary Bill Burns, 2020 Olds Tower, Lansing 8, Michigan. This will assist the local committee in making the necessary arrangements. The starting committee will assist players from the different states to arrange games with like handicaps, age, and specialty.

SURVEY OF PHYSICIANS' INCOMES

The Bureau of Medical Economic Research of the American Medical Association and the Office of Business Economics of the U. S. Department of Commerce are jointly conducting a survey of physicians' incomes.

The Bureau has been authorized by the A.M.A. Board of Trustees to cooperate in this survey, which the Department of Commerce had planned to conduct alone. It will be the first full-scale survey by the department of physicians' incomes since 1941.

An analysis of the results will be published by the Department of Commerce next fall in its monthly publication, *Survey of Current Business*. Its August 1949 and January 1950 issues had published similar analyses of surveys of incomes of dentists and lawyers, respectively, made jointly with the American Dental Association and the American Bar Association.

There is evidence that the national averages in some surveys have been too high because physicians who do not have bookkeepers to fill out questionnaires do not reply in sufficient numbers. Accordingly, the Bureau emphasizes the importance of all doctors, especially those with a relatively small practice, filling out the questionnaires.

Accurate postwar data on physicians' incomes is badly needed in order to develop better estimates of how much the American people pay to physicians.

Every physician can be assured that the survey has no relation whatever to the operations of the U. S. Bureau of Internal Revenue. There is no way by which the Department of Commerce could have obtained the needed information from the Bureau of Internal Revenue; hence, the questionnaire survey.

There will be two questionnaire forms. The Bureau of Medical Economic Research helped to design these. A short form will request income data for 1949 only. A long form questionnaire will cover the years 1945 through 1949. All are to be returned unsigned in franked envelopes.

The punch card files of the Bureau of Medical Economic Research contain the names of about 200,000 physicians. The survey will cover 125,000 of these, or 62½ per cent of the total. Selection will be by a formula which eliminates any partiality.

A short form will be sent once only to *every other* name in the file. Of the remaining 100,000 names, every fourth will be selected. To these will go 10,000 short forms and 15,000 long forms, with this distinction—the return franked envelopes will carry a code number which will identify the physician to the Bureau of Medical Economic Research alone. All of the addressing will be done in the headquarters of the A.M.A.

The sole purpose of the code number is to enable the Bureau of Medical Economic Research to address a follow-up letter to those not replying to the first request. Physicians need have no suspicion about the code number because when the reply is received, the questionnaire will be separated immediately from the envelope and the identity will be lost.

Physicians will be doing the medical profession a service by filling out the forms and returning them as soon as possible.

Through the efforts of the **Woman's Auxiliary to the Delaware-Blackford Counties Medical Society** all of the Federated Woman's Clubs of that territory have passed resolutions against compulsory health insurance. This total of 51 resolutions is now being added to by the activity of the Auxiliary with the nonfederated clubs, of which there are an even greater number.

GP, the journal of the American Academy of General Practice, made its initial appearance in April, 1950. Planned as a top quality journal, to be set up in an eye-appealing manner, with scientific presentations and other items of interest to its readers, the new arrival gives every evidence of fulfilling the prophecies of its sponsors.

Preparation of the first issue was completed after the accidental death of its first medical editor, Dr. F. Kenneth Albrecht, and before the announcement of the acceptance of the editorship by Dr. Walter C. Alvarez.

Besides the customary scientific articles, editorials, and letters, *GP* will have departments on Practical Therapeutics and a Current Journal Review. Answers to queries on medical matters will be published under the heading of "Information Please."

There will also be a department on Business and Economics, and reviews of newly published medical texts under the heading of "The Practitioner's Bookshelf." An innovation which will encourage something which busy doctors need more of—hobbies and pastimes—will be contained in a department entitled "After Hours."

The new journal is beautifully set up, with an excellent format, and outstanding illustrations. It is readable and enjoyable.

Included on the Editorial Advisory Board are Dr. W. D. Gatch and Dr. Harris B. Shumacker, Jr., of Indianapolis, for general surgery; and Dr. K. K. Chen, of Indianapolis, for pharmaceutical research and development.

Mac F. Cahal, the Executive Secretary of the Academy, is the Managing Publisher. Dr. Arthur N. Jay, Indianapolis, is a member of the Publication Committee, of which Dr. Stanley R. Truman, the current President of the Academy, is the Chairman.

Dr. **John A. Hetherington** has opened an office at 910 Hume Mansur Building, in Indianapolis, for the practice of neurological surgery. A 1943 graduate of Indiana University School of Medicine, he interned at Pontiac General Hospital, at Pontiac, Michigan. Following this he went into the Army, where he served as battalion surgeon for eighteen months, one year of which was spent in the European Theater. Leaving the service in January, 1946, he spent a year as resident in neurology at the Methodist Hospital, in Indianapolis, and for the past three years Doctor Hetherington has been at the Mayo Clinic, in neurological surgery.

The twenty-first annual convention of the **Aero Medical Association** will be held at the Palmer House, in Chicago, May 29, 30 and 31. Scientific papers will be presented by outstanding leaders in aviation medicine from England, Canada, and the United States. Dr. Hedwig S. Kuhn, of Hammond, will present a paper on "Industrial Eye Problems," on May 31, at 4:00 p. m. A complete program may be had by addressing Paul A. Campbell, M.D., chairman, Scientific Program Committee, 700 North Michigan Avenue, Chicago.

The Annual Meeting of the **American Goiter Association** at Houston, Texas, on March 9, 10 and 11, presented a two and one-half day program of papers on investigative and clinical study of thyroid diseases. F. N. Andrews, Ph.D., of Purdue University, read a most interesting report on "Natural and Experimental Alteration of Thyroid Function in Domestic Animals."

OVERSEAS HEALTH PERSONNEL

To meet the increasing demand for experienced health personnel to staff technical health missions overseas which have been authorized by Congress, the Division of International Health, Public Health Service, is developing an intensive recruiting program.

Opportunities for overseas assignments in the higher grades are expected to develop for a number of physicians.

Members of technical health missions can assist foreign governments in establishing public health training, initiate health demonstrations, supervise specific projects, and serve in an advisory capacity to foreign government officials on health matters.

Qualified health personnel may obtain application forms and further details concerning opportunities to participate in these programs by writing to the Chief, Division of International Health, Public Health Service, Federal Security Agency, Washington 25, D. C.

Dr. **Cleon A. Nafe**, of Indianapolis, has been appointed a member of the Board of Trustees of the Indianapolis Foundation and of the William E. English Foundation.

Dr. **Wilford Brockman**, of Fulda, is now associated in the practice of medicine with Dr. Martin Enlow at Corydon. Both of them are graduates of the University of Louisville School of Medicine.

Dr. **Lester D. Bibler**, of Indianapolis, was elected a member of the four-man Executive Committee of the American Association of General Practitioners, at their recent national convention in St. Louis.

The Indiana State Board of Health recently created an Evaluation Advisory Committee, to assist in the administration of programs referable to laboratory approvals for premarital and prenatal examinations. Members of the committee are: Drs. **L. G. Montgomery**, of Muncie, **W. E. Bayley**, of Lafayette, **F. R. Mercer**, of Fort Wayne, and **L. D. Bibler**, of Indianapolis.

POSTGRADUATE COURSE IN ENDOCRINOLOGY

A Postgraduate Course in Endocrinology will be conducted by the University of Illinois School of Medicine under the directorship of Dr. Willard O. Thompson, May 15 to 20, 1950. The course has been organized for the American College of Physicians, but other physicians may register, up to a maximum of 100. The fee for members is $30.00, for nonmembers $60.00.

This course will provide an intensive review of recent developments in the field of endocrinology, including endocrine gynecology and sterility. A considerable amount of time will be devoted to the clinical uses of ACTH and Cortisone and related steroids. Special attention will be paid to clinical disorders, and physiological and biochemical developments will be presented in relation to their bearing on the interpretation of clinical phenomena.

Leading teachers from all over the United States and Canada will take part in the course. Endocrine disorders will be illustrated by the presentation of patients during the last hour of each afternoon session. Men on the program will take part in the discussion of these cases. There will be a round table discussion each day at luncheon in which all men on the faculty that day will participate. This will provide an opportunity for the men taking the course to discuss various problems informally with the teachers. There will be morning and afternoon sessions each day except on Saturday, when there will be a morning session only.

Recently the American Reagents Company of Philadelphia distributed by mail to physicians advertising material on the iodoacetate test for cancer. In response to inquiries of a number of physicians, the following information has been released by the Indiana State Board of Health.

The test was announced by Dr. Charles Huggins, Chicago, at the annual meeting of the American Association for Cancer Research held in Detroit, April, 1949, and received a large amount of highly optimistic newspaper coverage. It is based on the delayed thermal coagulation demonstrated in the sera of patients suffering from cancer and certain other chronic illnesses as detected by the use of buffered iodoacetates.

Two well-equipped laboratories within this state are known to have been working with this test and have found the results to be very confusing. Certainly if the test cannot be relied upon in a well-staffed laboratory, it is not ready for use in the physicians' office, as this company advises.

Doctor Huggins, as well as other workers in the field, agree that their findings are not ready for general use and that at present it is an interesting phenomenon upon which future studies may be based.

The American Society for the Study of Sterility will hold its sixth annual conference at the Sir Francis Drake Hotel, in San Francisco, June 24 and 25. Registration fee for the session will be $10.00. Applications for registration should be addressed to the society, at 20 Magnolia Terrace, Springfield 3, Massachusetts.

The Sixteenth Annual Meeting of the **American College of Chest Physicians** will be held at the St. Francis Hotel, San Francisco, June 22 through 25, 1950. An interesting scientific program has been arranged for the meeting.

The Board of Examiners of the American College of Chest Physicians announces that the next oral and written examinations for Fellowship will be held in San Francisco, June 22, 1950. Candidates for Fellowship in the College who would like to take the examinations should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

Dr. Jerome V. Pace, New Albany, serves as Governor of the College for the State of Indiana, and Dr. James H. Stygall, Indianapolis, is the Regent for the district.

The Institute for Human Adjustment, in cooperation with the Extension Service of the University of Michigan, announces the **Third Annual Institute on Living in the Later Years**, to be held in Ann Arbor, Michigan, on June 28, 29 and 30. The program will consist of lectures, discussion groups, and demonstrations about the problems of old age.

REVISED EDITION OF MOTION PICTURE REVIEWS NOW AVAILABLE

The Committee on Medical Motion Pictures of the American Medical Association has completed the second revised edition of the booklet entitled "Reviews of Medical Motion Pictures." This booklet now contains 225 reviews of medical and health films reviewed in *The Journal of the American Medical Association* to January 1, 1950. Each film has been indexed according to subject matter. The purpose of these reviews is to provide a brief description and an evaluation of motion pictures which are available to the medical profession. Each film is reviewed by competent authorities and every effort has been made to publish frank, unbiased comments. Copies are available at a cost of 25 cents each from: Order Department, American Medical Association, 535 North Dearborn Street, Chicago 10.

GROWTH OF HEALTH COUNCILS SHOWS NATIONWIDE PROGRESS IN RURAL HEALTH

One of the brightest indications of progress in securing more doctors and better health facilities for rural areas is the announcement by the American Medical Association that community health councils in the nation have increased from 82 to nearly 300 in the last two years.

These figures are based on a recent survey of the association's Council on Medical Service in which county medical societies were queried, Thomas A. Hendricks of Chicago, secretary of the council, said.

Local achievements of the community health councils in the last five years include construction of hospitals with the aid of the Hospital Survey and Construction Act (Hill-Burton Act); increasing available hospital beds; developing clinics; securing more doctors, dentists, nurses and other needed personnel; development of full-time local public health services; health examination of children of school and pre-school age and correction of their remediable health defects; promotion of voluntary prepayment medical care and hospitalization; provision of medical care for the aged and chronically ill, and meeting costs of medical service to families unable to pay for hospitalization and doctors' bills, according to Mr. Hendricks.

CANCER FUND GRANTS

A grant of $25,000 was made to Dr. Edwin A. Lawrence, at Indiana University Medical Center, in Indianapolis, for improving the present training program.

Dr. Russell Sage, Indiana University School of Dentistry, has been issued a continuing grant in the amount of $4,560.72, for a supported training program.

A grant in the amount of $8,500 was issued to Dr. H. J. Muller, at Indiana University, Bloomington, for the production of mutations by ultraviolet rays in Drosophila.

AMERICAN HEART ASSOCIATION GRANTS $220,000 FOR HEART DISEASE RESEARCH

Grants-in-aid totaling $220,000 have been awarded for heart disease research to 46 universities, hospitals, institutes, and laboratories by the American Heart Association, it was announced by A. W. Robertson, Chairman of the Board. Mr. Robertson pointed out that the latest grants bring to approximately $400,000 the total funds voted by the American Heart Association during the past year for research to be conducted in the academic year 1950-51. This total does not include research funds independently allocated by affiliated local heart associations as part of their regional programs.

AEC APPROVES 41 RESEARCH PROPOSALS IN BIOLOGY AND MEDICINE

The U. S. Atomic Energy Commission approved 41 research proposals in the field of biology and medicine from November 1, 1949, through March 9, 1950, it was announced recently by Dr. Shields Warren, Director of the Atomic Energy Commission Division of Biology and Medicine.

The scope of the program under which AEC research support is extended in biology and medicine comprises the biological effects of radiations, including medical and cancer research, and, to a limited extent, the use of radioisotopes as tracers.

The newly-approved research proposals and renewals include two for Indiana, as follows:

Indiana University
Investigator: Dr. T. M. Sonneborn
Title: "The Specific Immobilization Substances (Antigens) of Paramecium Aurelia"

Purdue University (Purdue Research Foundation)
Investigators: Dr. Henry Koffler and Dr. Dorothy M. Powelson
Title: "The Comparative Biochemistry of Molecular Hydrogen: I—The Physiology of Hydrogen Bacteria"

The Cancer Control Committee of the Indiana State Medical Association held a meeting at the Claypool Hotel, in Indianapolis, on January 29. Committee members present were Drs. Russell Malcolm, Mell B. Welborn, Paul J. Bronson, and C. A. Stayton. Guests who appeared before the committee and took part in the discussion were Dr. C. S. Black, president of the state association; Dr. John VanNuys, dean of Indiana University School of Medicine; Dr. Edwin A. Lawrence, medical center; Dr. Lall Montgomery of Muncie; Drs. T. B. Rice, L. E. Burney, and W. C. Anderson, of the Indiana State Board of Health; and Mr. Rollis Weesner, executive director of the Indiana Cancer Society, Inc.

Dr. Adolph S. Rumreich was recently appointed Public Health Service Regional Medical Director for Federal Security Agency Region 5 with headquarters in Chicago. Region 5 includes Illinois, Indiana, Wisconsin and Minnesota.

Doctor Rumreich succeeds Dr. Frank V. Meriwether, newly named Regional Medical Director of Region 6 with headquarters in Atlanta. Doctor Rumreich has been in the Chicago office since 1941, directing Public Health Service activities in connection with the Hospital Facilities program.

'HEART KITCHEN' PROGRAM TO BENEFIT HOUSEWIVES

A new community program to aid the cardiac housewife in the management of her home will be presented shortly to affiliates of the American Heart Association by its Division of Public Health.

The Association has just completed a Picture Edition of *The Heart of the Home*, an expanded version of the booklet first prepared by the New York Heart Association to describe its Work Simplification Kitchen.

Requests for information on the Heart Kitchen, from a great many housewives as well as from a wide variety of employers, architects, engineers and contractors, prompted the American Heart Association to reprint the brochure with a Pictorial Supplement added.

The 1948 infant mortality rate for the United States was the lowest on record, according to Public Health Service figures released recently. The number of deaths under one year of age reported in the United States during 1948 was 113,169. The number of births in this year was 3,535,068, thus giving a rate of 32.0 deaths per 1,000 live births. The rate was 32.2 in 1947, and 47.0 in 1940. Rates for Indiana were 29.8 in 1948, 30.6 in 1947 and 42.1 in 1940. Provisional figures indicate a further decline in 1949 to an estimated national rate of 31 deaths under one year of age per 1,000 live births.

A.M.A. WASHINGTON OFFICE NEWS

More Economies On Way In Military Medicine. The flare-up over closing of hospitals is not the last word on the subject of Defense Department economies. It has been learned that another series of tightening-up moves is in the making; some will be aimed strictly at saving dollars, but others will have no direct relation to economy. Dr. Richard Meiling, director of the Office of Medical Services, will be prepared to defend the new actions as essential to an orderly, efficient service. He will explain, as he has in the past, that the economies are being effected without sacrificing the quality of medical service available to *military* personnel. Some of his critics will maintain, as they have in the past, that Dr. Meiling and Defense Secretary Johnson are moving too fast, and without due consideration for all the factors. There is concern among some military medical officers that any abrupt or drastic reorganization may wreck programs which have been built up carefully over the years. Right now many of these projects still are in the discussion phase, others are in final planning stages, and all require the formal approval of the secretary. The current investigation by a House subcommittee may have some effect on these plans. However, the fact is that at present they are moving ahead.

Hospitals, Consultants, Internships Under Scrutiny. Here is the general shape of reorganization plans in Defense military services.

1. Regardless what comes of the House hearings, hospitals and other facilities will be reduced in status or closed when they no longer can be justified under an integrated program—Army, Navy and Air Force.

   When Dr. Meiling took office last October, the services were staffing 46,281 beds for patients, which he described as "16,000 beds *in excess* of patient requirements." In addition, Dr. Meiling reports that the services had 50,000 "bed spaces" in facilities which were not staffed. Since then there have been a number of reductions and cutbacks, the most drastic being the programs now under Congressional investigation.

   Meanwhile, the Department is making a long-range study of its hospitals, preparatory to replacing semi-permanent structures on an orderly priority schedule. The hope is to arrive at a *single* general pattern for the three services and to decide on the *same type facilities.* One proposal is to have each new installation, regardless of size, capable of 100 per cent expansion.

2. *Recruitment* of doctors will continue. But the *total* number of doctors on active duty might even be reduced. Secretary Johnson has been informed that the essential problem is not how to obtain *more* doctors, but how to utilize *properly* approximately the present number.

   These are Defense Department figures on medical manpower: Total operational requirements of physicians for the three services, 5,639. Total physicians available for operational use, 3,982, plus 1,590 interns, residents and *civilian* doctors in *military* hospitals. The grand total of these is just 67 short of operational requirements—5,639. Another 1,206 *military* medical officers—interns and residents—are serving in *civilian* hospitals and therefore not available for treating military personnel. The total of all physicians in active military service and serving in all capacities is 7,216. A committee now is at work on the whole question of internships and residencies. It is seeking some system under which the three services could use these officers more efficiently as well as more economically.

3. There is some question within the Defense Department whether the civilian consultant program is run as efficiently and economically as it might be. In the last full year the three services hired 1,931 physicians on a consultant fee basis. Another committee is studying this question, attempting particularly to devise an appointment system which could be used by all three services and a practical method for joint utilization of the consultants.

4. Defense Department is making an analysis of the manner in which the three services calculate their medical personnel requirements—how they determine the number of doctors each needs and their distribution. At present three different systems are used; the hope is that a common formula can be arrived at.

5. A report, now under preparation, will attempt to solve the problem of the medical reserves. Dr. Meiling's office believes the present reserve program is *dangerously inadequate*, both as to numbers and as to type of training schedules. He is anxious to get more officers to participate in reserve activities and to develop programs which will keep the men and units in maximum readiness.

$42,500 Sought for Study of Nation's Health Problems. On Friday, Senate Labor and Welfare Committee will consider a request for $42,500 for a study of health problems of the nation, particularly the extent of coverage of voluntary health insurance plans. The proposal already has been approved by a subcommittee. Preliminary work (authorized by S. Res. 184) already has been completed and a report written but not yet released . . . . H. R. 4840, authorizing a study of the best method of surveying the nation's health, will get attention from the House Interstate and Foreign Commerce Committee in the near future.

Public Demand Spurs Big Appropriation For Cortisone and ACTH. *Grass-roots* appeals, from physicians and the public, are one explanation of why a House Committee *added* two and one half million dollars to an appropriation for research into cortisone and ACTH. The House Appropriations Committee, which historically does far more *reducing* than increasing, made the decision to spare no money on this project. It boosted a requested appropriation for National Institutes of Health from $1,100,000 to $3,600,000. The Committee acted after physicians and arthritic patients *in all parts* of the country made themselves heard in Washington. Senator Pepper received urgent appeals from two physicians in one city.

However, there is almost *no* possibility that these substances will be available for general treatment in the near future. The supply is infinitesimal in relation to demand; cost remains extremely high because only known production method is involved and expensive. At the end of 1949, ACTH was being produced at the rate of only *five pounds per month.* Cost of production is *$200 per gram,* which is the amount necessary to treat one case of rheumatic arthritis for just *20 days.* Cortisone is produced at a rate of 200 grams per month. This costs *$150 per gram,* and one gram of cortisone will treat a patient for only *10 days.*

We are informed that not much of either compound will be available for general treatment until output is increased more than one hundredfold. The point is, even Congress' generosity will not make these preparations generally available in the near future.

House Recess Holds Up Committee Work. The House Committee on Expenditures, which has heard only one day's testimony on United Medical Administration plan, will not return to this bill until some time next week at the earliest. Then the Committee is expected to call in a group of witnesses favorable to the proposal for grouping all federal medical and hospital services into one organization.

Witnesses already heard on H. R. 5182 denounced the idea for a variety of reasons. The Committee learned what the American Legion thought of the bill from four witnesses, including National Commander George E. Craig and the chief medical advisor, Dr. Leon G. Rountree. Mr. Craig said the plan would "dismember" the VA, and turn over its medical functions to a "new, untried, experimental" administration. Several Committee members told Mr. Craig the Legion's "pressure" methods and threats were not helping its case.

Dr. Charles W. Mayo of the Mayo Clinic said he firmly opposed returning VA doctors, dentists and nurses to Civil Service. He recalled that a separation of VA medical services from Civil Service controls "was one of the most important steps which contributed to the present (high) quality of VA medical care."

Council's Power Under Discussion In Medical Education Bill. The House Sub-committee continues to work out details of amendments to the Aid to Medical Education bill (H. R. 5940 and S. 1453). One question in the closed sessions is how much power to grant the advisory council in relation to the surgeon general. Originally the bill required that the surgeon general consult with the council prior to making grants to schools and colleges, but it did not require that he accept the council's view. The question now is whether to require the surgeon general to follow the decisions of the council. This is one of eight amendments on which the committee is trying to agree.

Work Progresses On Civil Defense Program. Working with A.M.A., the National Security Resources Board is getting into outline form a program that will fully integrate medical and health services in civil defense plans. Dr. Norvin Keifer, the board's medical director, will announce details shortly. . . . Dr. Robert Flynn has joined Dr. Keifer's staff, on a part-time loan from Public Health Service. Since December Dr. Flynn has been assigned to emergency medical service planning for PHS. During the war he was engaged in control of health hazards in explosives plants, and later served on the U. S. Strategic Bombing Survey.

Fewer VA Beds For Non-Service Connected Cases. Closing of five military General Hospitals by June 30, as scheduled, will mean still fewer beds available in VA hospitals for veterans with non-service connected ailments. At present, VA has 1,800 patients in the hospitals scheduled to be shut down. It is expected that a high percentage of these will have been released by June 30. The remainder will be absorbed in VA's own hospitals, whether service or non-service cases. In anticipation of this, VA will withhold beds that might otherwise be used for non-service cases. This is the second development within a week pointing toward less care available for non-service patients. Earlier VA said that it would have fewer beds available for these cases as a result of a personnel reduction in its medical and hospital departments.

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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Deaths

Thomas B. Noble, Sr., M.D., of Indianapolis, died on April 12, after a long illness. He was eighty-three years of age. A graduate of the Miami Medical College, of Cincinnati, in 1893, Doctor Noble had practiced surgery in Indianapolis since that time, and was a pioneer in surgical techniques. He was a member of the International College of Surgeons, an Honorary member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

David L. Phipps, M.D., retired physician of Union City, died on April 11, at the age of eighty-six. He was a graduate of the Kentucky School of Medicine, in Louisville, in 1892, and had practiced medicine in Whiteland for more than fifty years. Doctor Phipps was an Honorary member of the Johnson County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Walter A. Hornaday, M.D., formerly of Evansville, died in Birmingham, Alabama, on March 18, after an illness of two years. He was fifty-five years of age. He graduated from Indiana University School of Medicine in 1924, and had practiced in Hammond before going to Evansville to practice. He was a member of the Vanderburgh County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Pierre J. Fisher, M.D., of Marion, died on March 10, after a long illness. He was fifty-six years of age. He was a graduate of the Northwestern University School of Medicine, in Chicago, in 1931, and had practiced in Marion for the past eighteen years. He was a veteran of World War I, and was a member of the Grant County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Augustus Grote Pohlman, M.D., former professor of anatomy at Indiana University, died on March 31 at Hermosa Beach, California. He had been living in California since his retirement.

John J. Gibson, M.D., of Alexandria, died suddenly on March 24, at the age of eighty-four. A native of Canada, Doctor Gibson graduated from Queen's University Faculty of Medicine, Kingston, Ontario, in 1893, and he located in Alexandria in that year, where he has practiced ever since. He was an Honorary member of the Madison County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Benjamin Franklin Kuhn, M.D., retired physician of Pierceton, died on April 4, at the age of eighty. He graduated from the Bennett Medical College, in Chicago, in 1897, and practiced surgery in Elkhart for forty-four years, before retiring and moving to Pierceton, in 1941. He was an Honorary member of the Elkhart County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

David F. Berry, M.D., of Indianapolis, died on March 16, at the age of seventy-six. He was a native of Franklin, graduate of the Central College of Physicians and Surgeons, in Indianapolis, in 1900, and he had practiced in Indianapolis for forty years. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

Irvin E. Booher, M.D., of Connersville, died suddenly on March 15. He was sixty-seven years of age. He was a graduate of the University of Louisville School of Medicine, in 1913, and had practiced in Connersville since that time. Doctor Booher was a veteran of World War I, and was a member of the Fayette-Franklin County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Byron Merle Hutchings, M.D., of Terre Haute, died in Crawfordsville on April 5, after a short illness. He was seventy years of age. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1903. Doctor Hutchings was a member of the Vigo County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

March 5, 1950

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D.; W. U. Kennedy, M.D.; A. F. Weyerbacher, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Guest: Glen Ward Lee, M.D., chairman, Committee on Veterans Affairs and Rehabilitation.

Membership Report

Number of members February 28, 1950	*3,058
Number of members February 28, 1949	3,273
Loss over last year	215

* Includes 34 in military service (gratis); 185 senior members; 138 $10 members.

Number of members December 31, 1949	3,758

Statements of receipts and expenditures for January and February for the association and THE JOURNAL were approved.

Treasurer's Office

The treasurer proposed that the association purchase single certificates in Blue Cross and Blue Shield for the employees of the headquarters office and THE JOURNAL office, to become effective June 1, 1950. On motion of Drs. Ellison and Clark, the Executive Committee approved this suggestion, which is to be referred to the Council at its spring meeting on April 16.

1949 Annual Session, Indianapolis, September 26-29,1949

The executive secretary reported that the Indiana State Library had offered to assemble and preserve the centennial convention material, and on motion of Drs. Clark and Ellison the Executive Committee voted to accept this offer.

1950 Annual Session, French Lick, September 25, 26 and 27, 1950

On motion of Drs. Clark and Ellison, permission was given the Indiana Academy of General Practice to set up an exhibit.

Legislative Matters

National

After a discussion of conflicting opinions between the American Medical Association and the Association of American Physicians and Surgeons over opposition to, and support of, certain bills now before Congress, it was taken by consent that the Executive Committee reaffirm its policy of following the A.M.A. leadership, and it was decided to have Dr. Wright outline the position of the Indiana State Medical Association to the Council at its meeting on April 16.

Local

The executive secretary reported on the activities of the Committee on Public Policy and Legislation.

Indiana A.M.A. Campaign Coordinating Committee

The field secretary gave a brief report on the activities of the Indiana A.M.A. Campaign Coordinating Committee, including the work of the Woman's Auxiliary. It was taken by consent that the association continue to use the services of the Woman's Auxiliary in the campaign against socialized medicine.

On motion of Drs. Clark and Kennedy, the suggestion is to be made that the Auxiliary be asked to appoint a committee from its membership to assist the state association in its drive against socialized medicine and that the chairman of the said committee be made a member of the Indiana A.M.A. Campaign Coordinating Committee.

Organization Matters

Authorization was given the field secretary to go to Michigan to collect data on the rural health organization in that state.

Rural Health Committee and Blue Shield. On motion of Drs. Clark and Kennedy, the committee gave approval for the Committee on Rural Health to work with Blue Shield.

Organization of new Woman's Auxiliary units. The policy of encouraging organization of auxiliary units in counties not having them was adopted by consent.

Public housing project. The president-elect reported that the St. Joseph County Medical Society had gone on record as opposing the public housing project in South Bend. On motion of Drs. Clark and Ellison, the Executive Committee expressed itself as in agreement with the action of the St. Joseph County Medical Society.

Grievance Committee. The president read a letter from the office of the association's attorney, expressing the opinion that his appointment of a Grievance Committee as a subcommittee to the Committee on Public Relations was done in accordance with the By-laws of the association.

The chairman of the Committee on Veterans Affairs and Rehabilitation was authorized to attend the semiannual meeting of the Council on National Emergency Medical Service in Chicago on April 22, 1950.

A suggestion made by the councilor of the Thirteenth District that greater effort be made to increase enrollment in Blue Shield and Blue Cross was referred to the Committee on Prepaid Medical and Hospital Insurance.

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The president and executive secretary were selected to represent the association at the centennial convention of the Missouri State Medical Association at St. Louis on March 27 and 28, on motion of Drs. Weyerbacher and Clark.

Standards of approval for disability insurance. On motion of Drs. Clark and Kennedy, the committee approved the suggestion of Mr. Richard A. Calkins for setting up standards for health and accident insurance. This action is to be referred to the Council.

On motion of Drs. Kennedy and Clark, Dr. A. M. Mitchell, of Terre Haute, was selected as Indiana's representative on the Committee for National Conference of County Medical Society Officers.

Membership in Conference of Presidents. On motion of Drs. Ellison and Clark, a $50.00 membership in the Conference of Presidents was voted by the committee.

Research Council for Economic Security. On motion of Drs. Clark and Black, the request of the Research Council for Economic Security for a contribution was tabled.

On motion of Drs. Kennedy and Clark, the following physicians were approved and recommended for membership on the Board of Directors of Mutual Medical Insurance, Inc.: W. H. Howard, M.D.; R. R. Calvert, M.D.; E. H. Clauser, M.D.; I. C. Barclay, M.D.; M. B. Catlett, M.D.

Request for funds from the Los Angeles County Physicians Aid Association was read, and the executive secretary was instructed to acknowledge the letter, but no action was taken.

Veterans fee schedule. The chairman of the Committee on Veterans Affairs and Rehabilitation read the proposed amendments to the veterans fee schedule, which were approved on motion of Drs. Clark and Kennedy. On motion of Drs. Clark and Kennedy, the Executive Committee directed the Committee on Veterans Affairs and Rehabilitation to enter into a new contract with the Veterans Administration, beginning July 1, 1950, providing the amendments are acceptable to the VA.

The Journal

Report on advertising:

Total advertising in January issue	$2,183.17
Total advertising in February issue	$2,013.46

Subscription price schedule. On motion of Drs. Clark and Kennedy, the following subscription price schedule was adopted:

Regular subscription	$5.00
Hospitals, libraries, universities, agencies	4.00
Advertisers and representatives	2.50
Medical students and interns	1.00
Foreign	6.50

Approval of the proposal of University Microfilms was delayed pending word from the American Medical Association as to the reliability of this company.

There being no further business, the Executive Committee adjourned, to meet again at 6:00 p.m. Saturday, April 15, 1950, at the Columbia Club.

COMMITTEE ON PUBLICITY

March 10, 1950

Present: Marlow W. Manion, M.D., chairman; Homer G. Hamer, M.D.; James O. Ritchey, M.D.; Ray E. Smith, executive secretary, and Jas. A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of April 10, 1950—"Spring Hay Fever"
Week of April 17, 1950—"Spring Exercise"
Week of April 24, 1950—"Length of Life"

The committee accepted the invitation of the Hoosier State Press Association to purchase a page in the April issue of *The Indiana Publisher*, at a cost of $40.00. The executive secretary was directed to prepare copy for the advertisement.

A letter sent to the American Medical Association by the secretary of the Tippecanoe County Medical Society, asking for a speaker on "What May the Physicians in General Practice Look Forward To?", and which was referred to the committee by the A.M.A., was returned to the A.M.A. with the suggestion that it answer. The committee decided that the responsibility of taking care of the request was primarily that of the A.M.A.

March 24, 1950

Present: Marlow W. Manion, M.D., chairman; Homer G. Hamer, M.D.; James O. Ritchey, M.D.; Mrs. Truman E. Caylor, president of Woman's Auxiliary to the State Medical Association; John F. Kirwan, representing America's Future, Inc.; Ray E. Smith, executive secretary, and Jas. A. Waggener, field secretary.

Copy of letter written by the executive secretary to Thomas A. Hendricks, secretary of the A.M.A. Council on Medical Service, regarding request of the Tippecanoe County Medical Society for a speaker on "What May the Physicians in General Practice Look Forward To?", and a copy of the letter sent by Mr. Hendricks to the secretary of the Tippecanoe County Medical Society were read.

Request of the Work Study Group on Education of the Public by Radio of the Ohio State Medical Association for the state association to participate in the Institute for Education by Radio at Columbus, Ohio, May 4-7, 1950, was tabled.

Mr. Kirwan presented two of a series of fifty-two fifteen-minute radio transcriptions offered by America's Future, Inc. The committee directed the executive secretary to write the home office to see what rate would be given the committee if it agreed to pay the charges, quoted at $5.00 a week by Mr. Kirwan, for all county medical societies who wanted the records for broadcasting locally. The executive secretary was instructed to ask the A.M.A. about the America's Future organization.

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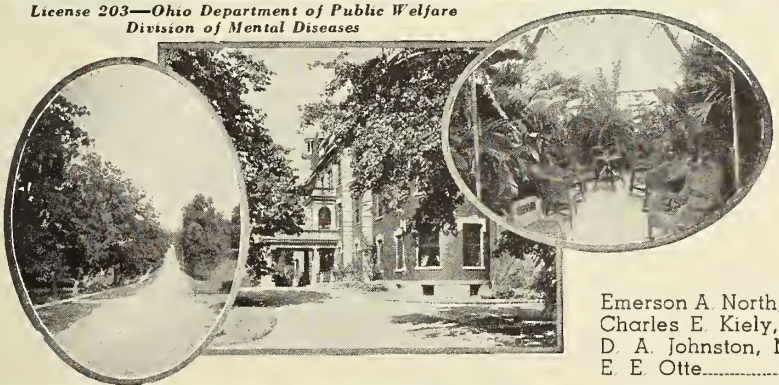

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COUNCILOR DISTRICT MEETING

Twelfth District

Dr. A. R. Savage of Fort Wayne was elected president of the Twelfth District Medical Society at the 1950 meeting held in Fort Wayne on April 4. Other officers elected were: Dr. W. J. Gerding of Fort Wayne, vice-president; Dr. E. H. Schlegel of Fort Wayne, secretary-treasurer; and Dr. Myron L. Habegger of Berne, alternate councilor.

More than 130 physicians and their wives attended the dinner in the evening. Dr. James A. Doenges of Anderson spoke on "The Doctor as a Community Leader." Dr. P. T. Lamey of Anderson, president of the Madison County Medical Society, explained how the society set up its organization to oppose socialistic legislation at Washington. Dr. M. B. Catlett of Fort Wayne, councilor, presided.

In the afternoon the following scientific program was presented:

"The Concept of the Male Climacteric," by Dr. Richard L. Landau, assistant professor of medicine, University of Chicago School of Medicine.

"Vertigo," by Dr. John R. Lindsay, professor of otolaryngology, University of Chicago School of Medicine.

"The Diagnosis and Prognosis of Coronary Arteriosclerosis," by Dr. Wright Adams, professor of medicine, University of Chicago School of Medicine.

Guests at the meeting included Dr. C. S. Black of Warren, president of the Indiana State Medical Association; Dr. J. William Wright of Indianapolis, co-chairman of the Committee on Public Policy and Legislation; Ray E. Smith and James A. Waggener, executive secretary and field secretary, respectively, of the state association; and R. S. Saylor, executive vice-president of Mutual Medical Insurance, Inc.

The twelfth district Woman's Auxiliary to the Indiana State Medical Association held its meeting in the Fort Wayne Y.W.C.A. during the afternoon. Mr. James A. Waggener spoke on the Indiana Educational Campaign.

LOCAL SOCIETY REPORTS

LOCAL SOCIETY OFFICERS

CARROLL COUNTY MEDICAL SOCIETY
President, Charles C. Crampton, Delphi,
Vice-President, Eva N. Kennedy, Camden,
Secretary-Treasurer, Thomas C. Brown, Delphi.

DAVIESS-MARTIN COUNTIES MEDICAL SOCIETY
President, L. M. McNaughton, Washington,
Vice-President, Don Sears, Odon,
Secretary-Treasurer, H. O. Norton, Washington.

DEARBORN-OHIO COUNTIES MEDICAL SOCIETY
President, George Vail, Lawrenceburg,
Vice-President, J. K. Jackson, Aurora,
Secretary, Charles N. Manley, Rising Sun,
Treasurer, F. D. Houston, Lawrenceburg.

JASPER-NEWTON COUNTIES MEDICAL SOCIETY
President, Irvin Zeiger, Morocco,
Secretary-Treasurer, E. R. Beaver, Rensselaer.

JEFFERSON COUNTY MEDICAL SOCIETY
President, Lewis E. Jolly, Madison,
Vice-President, M. W. Kemp, Madison,
Secretary-Treasurer, O. A. Turner, Madison.

LA PORTE COUNTY MEDICAL SOCIETY
President, Victor F. Kling, Michigan City,
Vice-President, Mitchell J. Hetman, Westville,
Secretary-Treasurer, Carl N. Fischer, LaPorte.

POSEY COUNTY MEDICAL SOCIETY
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Vice-President, J. W. Herr, Mount Vernon,
Secretary-Treasurer, L. J. Vogel, Mount Vernon.

PULASKI COUNTY MEDICAL SOCIETY
President, C. Linton, Medaryville,
Secretary-Treasurer, T. E. Carneal, Winamac.

RANDOLPH COUNTY MEDICAL SOCIETY
President, Leroy B. Chambers, Union City,
Vice-President, Henry R. Shallenberger, Modoc,
Secretary-Treasurer, B. F. Wills, Union City.

SWITZERLAND COUNTY MEDICAL SOCIETY
President, George Ellerbrook, Vevay,
Vice-President, L. H. Bear, Vevay.
Secretary-Treasurer, Harold R. Griffith, Vevay.

Clay County Medical Society members met at the Elks Home in Brazil, on March 14. This was a business meeting, and ten members were present.

Fayette-Franklin County Medical Society members held a meeting on March 14, when twelve members were present. A film on "Malnutrition in the Hospital Patient" was shown.

Floyd County Medical Society members held a meeting in New Albany on March 10, when plans for the new hospital were presented. Fourteen members were present.

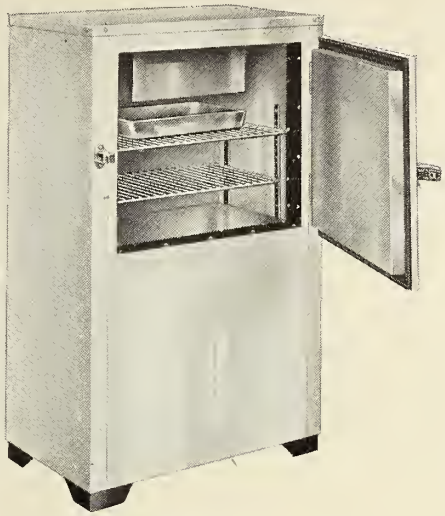
Hendricks County Medical Society members met at Avon on March 7. Dr. Russell Sage, of Indianapolis, was the guest speaker. His subject was "Lesions of the Mouth." Seven members were present.

Howard County Medical Society members met at Duke's Restaurant in Kokomo on April 7. Dr. R. A. Solomon, of Indianapolis, discussed "Antibiotics." Twenty-eight members were present.

Huntington County Medical Society members held a meeting in Huntington on March 6. Mr. Wilson D. Criswell discussed "Economics and Investments," and Professor Smith, of Purdue University, discussed rural health education. Nineteen members were present.

Another meeting was held on April 4. This was a business session, and seventeen members were present.

Madison County Medical Society members met at the Anderson Country Club on March 20. Mr. John H. Hunt, executive secretary of the American Society of Anesthesiologists, of Chicago, spoke on "Anesthesiology and the Practice of Medicine." Forty-one members were present.



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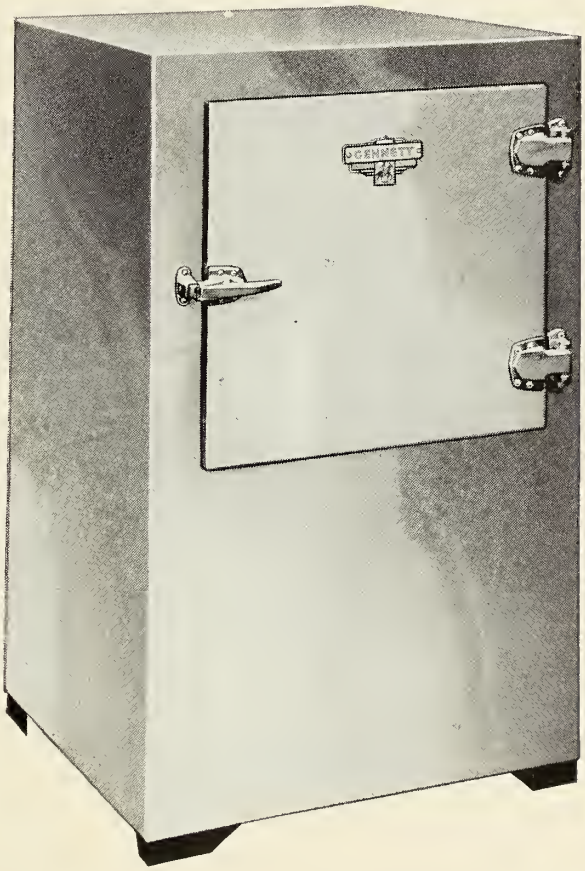

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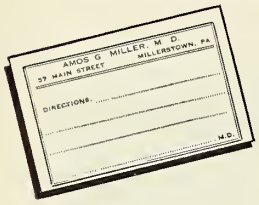

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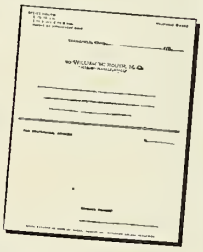

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Miami County Medical Society members met at the Knights of Columbus Home in Peru, on March 31. Guest speakers were Dr. Karl Ruddell, of Indianapolis, and Mr. W. W. Welsh, of Peru, who discussed socialized medicine in Europe. Nineteen members were present.

Owen-Monroe County Medical Society members met at the Bloomington Country Club on March 30. Guest speakers were Dr. Frank Gastineau and Dr. James Gosman, of Indianapolis, who spoke on "Common Skin Disorders."

Randolph County Medical Society members met at the Randolph County Hospital in Winchester on March 13. Fourteen members were present, to hear Dr. T. R. Hayes, of Muncie, discuss "Nephritis on Clinical Basis."

Vanderburgh County Medical Society members met at the Hotel McCurdy on March 14. The guest speaker was Dr. Leslie W. Freeman, of Indianapolis, who spoke on "Medical and Surgical Problems of Paraplegia and Rehabilitation of Paraplegic Cases."

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. Truman Caylor, Bluffton.

President-elect—Mrs. D. E. Lybrook, Galveston.

Corresponding Secretary—Mrs. Harry Harvey, Fort Wayne.

Recording Secretary—Mrs. Bert Ellis, Indianapolis.

Treasurer—Mrs. Wendell Kelley, Anderson.

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27TH ANNUAL MEETING WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

Hotel Fairmont, San Francisco, June 26 to 30, 1950

A cordial invitation has been extended to all members of the Woman's Auxiliary to the American Medical Association, their guests, and guests of physicians attending the convention of the American Medical Association, to participate in all social functions and to attend the general session of the auxiliary. Headquarters will be at the Fairmont Hotel. Tickets will be available at the registration desk only.

Indiana has been honored in having Mrs. Truman Caylor, immediate past president of the Woman's Auxiliary to the Indiana State Medical Association, give the response to the Address of Welcome on Tuesday, June 27, by the president of the Woman's Auxiliary to the California Medical Association.

For information concerning the complete program of the auxiliary, contact Mrs. Truman Caylor, Bluffton, or write to Margaret N. Wolfe, Executive Secretary of the Woman's Auxiliary to the American Medical Association, 535 North Dearborn Street, Chicago 10.

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—JANUARY 1950

Disease	Jan. 1950	Dec. 1949	Nov. 1949	Jan. 1949	Jan. 1948
Brucellosis	1	2	0	0	9
Chickenpox	341	236	140	681	662
Diarrhea, infectious	9	0	0	0	1
Diphtheria	26	33	38	38	44
Dysentery, bacillary	4	0	0	0	1
Food infection	1	2	1	0	0
Encephalitis	2	3	2	6	3
Impetigo	5	5	0	3	5
Influenza	53	26	20	134	94
Measles	211	111	92	267	1881
Meningitis,					
Influenzal	2	4	0	3	2
Meningococcal	6	8	2	4	5
Unclassified	5	4	5	9	5
Meningococcemia	1	0	0	0	0
Mumps	183	147	72	193	558
Paratyphoid fever	1	1	0	0	0
Pneumonia	51	45	26	83	72
Poliomyelitis	11	29	65	4	6
Rabies in animals	29	39	36	83	47
Rheumatic fever	2	0	0	2	0
Rubella	23	75	15	12	11
Scarlet fever	192	200	118	250	286
Tinea capitis	1	3	7	5	40
Tuberculosis,					
Pulmonary	221	111	168	238	214
Other forms	7	8	18	16	15
Tularemia	1	7	0	1	3
Typhoid fever	6	3	3	3	0
Vincent's angina	1	4	0	0	5
Whooping cough	100	87	88	80	164

MONTHLY REPORT—FEBRUARY, 1950

Diseases	Feb. 1950	Jan. 1950	Dec. 1949	Feb. 1949	Feb. 1948
Chickenpox	363	341	236	524	579
Conjunctivitis	1	0	0	10	1
Diphtheria	24	26	33	29	65
Dysentery, amebic	3	0	0	4	0
Encephalitis	2	2	3	2	3
Erysipelas	3	0	3	4	2
Influenza	37	53	26	52	110
Infectious hepatitis	17	0	0	0	0
Malaria	1	0	1	0	2
Measles	676	211	111	372	2707
Meningitis,					
Meningococcal	1	6	8	8	3
Unclassified	8	5	4	6	3
Mumps	161	183	147	163	766
Pneumonia	32	51	45	151	37
Poliomyelitis	2	11	29	3	1
Rabies in animals	55	29	39	74	63
Rubella	52	23	75	70	32
Scabies	1	0	0	6	0
Scarlet fever	210	192	200	284	361
Tuberculosis,					
Pulmonary	170	221	111	244	149
Other forms	14	7	8	15	20
Tularemia	2	1	7	3	2
Typhoid fever	3	6	3	3	5
Vincent's angina	1	1	4	0	4
Whooping cough	157	100	87	112	161

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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

BOOKS RECEIVED

THE SALT-FREE DIET COOK BOOK. By Emil G. Conason, M.D., and Ella Metz, dietitian. 137 pages. Price $3.00. Lear Publishers, New York City, 1949.

A CENTURY OF MEDICINE IN JACKSONVILLE AND DUVAL COUNTY. By Webster Merrit, M.D., Jacksonville, Florida. 201 pages, with 46 illustrations. Price, $3.50. The University of Florida Press, Gainesville, Florida, 1949.

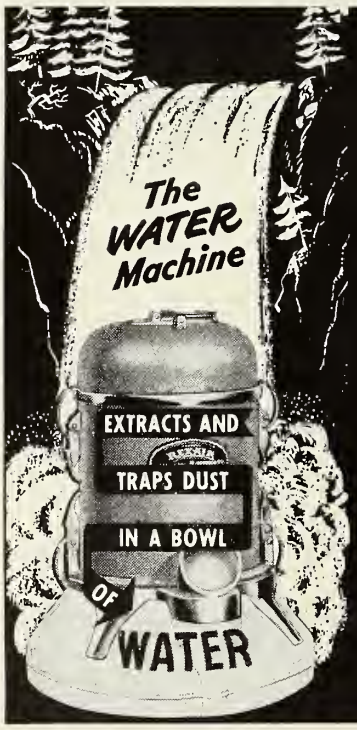
CURRENT THERAPY 1950. Latest Approved Methods of Treatment for the Practicing Physician. Editor: Howard F. Conn, M.D. Consulting Editors: M. Edward Davis, Vincent J. Derbes, Garfield G. Duncan, Hugh J. Jewett, William J. Kerr, Perrin H. Long, H. Houston Merritt, Paul A. O'Leary, Walter L. Palmer, Hobart A. Reimann, Cyrus C. Sturgis, Robert H. Williams. 736 pages. Price, $10.00. W. B. Saunders Company, Philadelphia, 1950.

Mitchell-Nelson's TEXTBOOK OF PEDIATRICS. Edited by Waldo E. Nelson, M.D., professor of pediatrics, Temple University School of Medicine; medical director, Saint Christopher's Hospital for Children, Philadelphia. With the collaboration of 63 contributors. 5th edition. 1658 pages with 426 illustrations, 19 in color. Price $12.50. W. B. Saunders Company, Philadelphia, 1950.

POSTGRADUATE GASTROENTEROLOGY. As Presented in a Course Given Under the Sponsorship of the American College of Physicians in Philadelphia. Edited by Henry L. Bockus, M.D., professor of gastroenterology, University of Pennsylvania Graduate School of Medicine. 670 pages with 258 figures. Price, $10.00. W. B. Saunders Company, Philadelphia, 1950.

THE CYTOLOGIC DIAGNOSIS OF CANCER. By the staff of the Vincent Memorial Laboratory of the Vincent Memorial Hospital, a gynecologic service affiliated with the Massachusetts General Hospital, Boston, the department of gynecology, Harvard Medical School. Published under the sponsorship of the American Cancer Society. 229 pages with 153 figures. Price, $6.50. W. B. Saunders Company, Philadelphia, 1950.

UROLOGICAL SURGERY. By Austin Ingram Dodson, M.D., Richmond, Virginia, professor of urology, Medical College of Virginia; urologist to Crippled Children's Hospital, St. Elizabeth's Hospital, St. Luke's Hospital, and McGuire Clinic. 2nd edition. 855 pages with 645 illustrations. Price, $13.50. The C. V. Mosby Company, St. Louis, 1950.



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Books

BOOKS REVIEWED

A TEXTBOOK OF SURGERY by American Authors: Edited by Frederick Christopher, M.D., Professor of Surgery, Northwestern University Medical School; Chief Surgeon, Evanston (Illinois) Hospital. Fifth Edition. 1550 pages with 1465 illustrations on 742 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price $13.00.

To "review" a work of this magnitude with any claim to doing it justice is scarcely within the scope of a few paragraphs. The editor is sufficiently well known to require no introduction to surgeons, and to students we can heartily recommend him.

The book is divided into 41 chapters, chiefly on an anatomical basis, such as the head, the neck, the nervous system, etc., but there are also chapters on inflammation and wound healing, shock, different aspects of bacteriology, fractures, dislocations, aseptic technique, care of surgical patients, roentgenology and anesthesia.

Each chapter contains from one to 23 sections, each section by one of the 198 able contributors. For instance, the chapter on stomach and duodenum has a section on gastric ulcer by A. W. Allen and C. E. Welch, one on tumors of the stomach by D. C. Balfour and J. M. Waugh, one on syphilis of the stomach by K. A. Meyer, on nonulcerative lesions of the duodenum by A. O. Whipple, and one on duodenal ulcer by J. J. Morton, besides other sections. Smith-Petersen has a beautifully prepared section on painful affections of the lower back in the chapter on deformities and derangements of bones and joints, and so on.

In spite of the tremendous extent of the field which is covered, its condensation into one volume has been accomplished in a most acceptable manner and seems entirely adequate for textbook purposes. It is such an improvement over the textbook this reviewer used as a student that there is no comparison. Each section of each chapter has a sufficient, but not dismaying, bibliography at the end, so that the subject is complete within its chapter. The text is arranged two columns to the page and the type is clear and easy to read. The index comprises 34 pages of 3 columns each and seems adequate. The illustrations are well chosen and for the most part clear, though a few have had to be reduced overmuch.

The express purpose of this fifth edition is to bring the work up to date and it is surprising how well this has been done, yet as the editor assures us in the preface, "Debatable or incompletely tried methods are not included." Perhaps the key to the overall excellence of this textbook is best stated as the editor puts it: "The contributors, whose painstaking work has made this book possible, have been chosen after careful thought and consultation because of their outstanding ability in the subjects which they present. With few exceptions these men are actively engaged in teaching surgery, and each has presented his material in the manner he has found to be most successful in instructing his medical students." Doctor Christopher has wrought well.

A. W. C.

ELECTROCARDIOGRAPHY—Fundamentals and Clinical Application. By Louis Wolf, M.D., visiting physician, consultant in cardiology, and chief of the Electrocardiographic Laboratory, Beth Israel Hospital: associate in medicine, Harvard Medical School. 187 pages with 110 figures. Price $4.50. W. B. Saunders Company, Philadelphia, 1950.

The first section of the book is devoted to a discussion of the basic principles involved in the production of both normal and abnormal electrocardiograms. The author has found this approach to the problems of electrocardiography to be most satisfactory. It is hoped that a knowledge of these principles will enable the physician to interpret the electrocardiogram on the basis of electrical phenomena rather than on empirical methods.

In the second part of the book these ideas have been utilized in the interpretation of electrocardiograms obtained in some of the common disorders involving the myocardium and the intracardiac conduction system.

The usual presentation of cardiac arrhythmias has been omitted.

The book is recommended for the beginner in electrocardiography.

K.G.K.

SHEARER'S MANUAL OF HUMAN DISSECTION— 2nd Edition. Edited by Charles E. Tobin, Ph.D., Associate Professor of Anatomy, University of Rochester School of Medicine and Dentistry. 286 pages with 79 illustrations. Price $4.50. The Blakiston Company, Philadelphia, 1949.

The author has accomplished the noteworthy improvement of an already well-established and admirable textbook for human dissection. The general format of the book has been retained, but very desirable and striking difference is evident in the reorganization of text description, in the emphasis of more important structures by bold face type and more sharply delineated illustrations.

The plan of dissection is adaptable to any sequence of regional dissection, but at the same time encourages the dissector to coordinate local findings with the general systemic arrangement of the entire body. Although the manual of dissection is not geared to any one method or treatise of anatomy, it is equally applicable to supplementation by all of the standard textbooks of anatomy. This feature should be considered an asset rather than a liability. In the hands of advanced students of anatomy, both at the undergraduate as well as the postgraduate level, and especially in the courses of clinical anatomy, the manual of dissection by Shearer has proved of greatest value. The improved edition as revised by Charles Tobin should prove to be a worth-while contribution to the field of anatomy, both in its academic preclinical phase as well as in the more advanced practical and clinical application.

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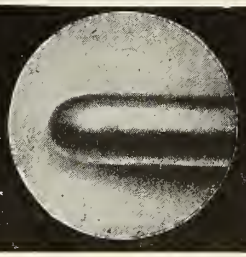

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CLINICAL PATHOLOGY—Application and Interpretation. By Benjamin B. Wells, M.D., professor of medicine, University of Arkansas School of Medicine. 397 pages with 32 figures. Price, $6.00. W. B. Saunders Company, Philadelphia, 1950.

This book attempts to evaluate the laboratory procedures available in studying a patient presenting a particular picture. The procedures are discussed under each disease or group of diseases where indicated without cross reference, so there is some repetition. The book's value lies in this form of organization rather than on any newness of material. The reviewer finds himself in full agreement with the stress placed on certain tests and particularly with the limitations which the author frequently places on tests which are used more or less uncritically. The book avoids discussion of technique except in cases where the technique is so complex that a doctor should understand just what he is asking the laboratory available to him to do. The appendix includes a tabulation of normal values for most tests and a concise interpretation of the variations from these normals.—S. L. J.

DOCTORS OF INFAMY. The Story of the Nazi Medical Crimes. By Alexander Mitscherlich, M.D., head of the German Medical Commission to Military Tribunal No. 1, Nuremberg, and Fred Mielke. 172 pages, with 16 pages of photographs. Cloth. Price $3.00. Henry Schuman, Inc., Publishers, New York, 1949.

This book is a translation of the report of Dr. Mitscherlich, Head of the German Medical Commission to Military Tribunal No. 1, Nuremberg, to which the publisher has added statements by three American authorities identified with the Nuremberg Medical Trial: Andrew C. Ivy, M.D., Telford Taylor, and Leo Alexander, M.D.

The book consists of an abstract of the material presented at the trial of twenty-three German defendants who were indicted in 1946 and tried before a war crimes tribunal at Nuremberg. Twenty of the defendants were physicians.

The abstract shows convincing evidence that these men, as officials of the German government, conducted experiments using human beings as experimental animals. The human beings were Jews, Poles, Russians and Slovakians who were either political prisoners or prisoners of war. The experiments involved subjections to low pressure, low temperature and the drinking of sea water, done primarily for the German Air Force; experiments with typhus and infectious jaundice, in which prisoners were deliberately infected; experiments with sulfonamide, bone-grafting, cellulitis and mustard gas in which human beings, apparently normal, were subjected to various toxic agents or deliberately infected; a collection of skulls of Jews for Strassburg University for which corpses were sent directly from the gas chambers to the Department of Anatomy.

There is also an abstract of testimony concerning the euthanasia program, the direct extermination of racial groups and undesirable patients, and experimental work in mass sterilization.

The material presented appears to be well authenticated. It is shocking and horrifying, particularly to any physician who has been trained in an American school. Even more shocking is the evidence that although only about two hundred physicians and laymen were directly involved in the program, there is no evidence of any objection or resistance to its anywhere by officials of the German government or representatives of the German people.

There is no indication that any useful information whatever was gained by this appalling human sacrifice.

B.W.S.

INTRODUCTION TO PSYCHOMATIC MEDICINE. By C. Alberto Seguin, M.D., professor of psychosomatic medicine, University of San Marco, Lima. 320 pages. Price $5.00. International Universities Press, Inc., New York City, 1950.

In view of current interest in the psychosomatic aspects of medicine, Professor Seguin has written a timely book. In the introductory chapters he points out the importance of considering the concept of unity, or the wholeness of the organism, in the care of the individual who is ill, and how frequently our clinical vision is obscured by focusing on systems, organs or diseases.

One chapter is devoted to the anatomy and physiology of the hypothalamus and the part it plays in the emotional and subconscious mechanism.

A great part of the book is devoted to the history and development of psychoanalysis. Today works on that subject certainly present a surplus problem in medical literature. Both the Freudian psychologic theory and that of Adler are discussed at considerable length.

One chapter is devoted to pathogenic psychosomatic mechanisms and interestingly shows how unresolved conflicts may be symbolically expressed through organic symptoms. Of course, these facts have been recognized by physicians for centuries, but still deserve emphasis.

The author discusses the psychosomatic factor in diseases such as: peptic ulcer, hypertension, asthma, colitis, skin, and endocrine disorders.

The entire work is supported by an extensive bibliography and a few illustrative cases are presented. Historic background and psychologic theory are ample. The book is worth reading by any medical practitioner since it is generally recognized that at least a third of the patients who consult physicians are suffering from functional and not organic disorders.

D.A.B.

PRACTICAL AND THEORETICAL ASPECTS OF PSYCHOANALYSIS. By Lawrence S. Kubie, M.D., clinical professor of psychiatry and mental hygiene, Yale University School of Medicine; faculty, New York Psychoanalytic Institute. 252 pages. Price $4.00. International Universities Press, New York City, 1950.

This book will be of value to the physician or lay person who is interested in psychoanalysis both from the practical and theoretical standpoint. Doctor Kubie, in a clear-cut, understandable manner, discusses psychoanalyses, answering questions which are bound to rise regarding free association, transference, the role of dream analysis, the use of the couch in the analytic process, the choice of an analyst and the fee for analyses.

The chapters dealing with psychoanalysis and moral responsibility, psychoanalysis and marriage, and misconceptions about psychoanalysis are especially well written.

Doctor Kubie discusses controversies regarding theory and technique which have arisen between certain analytic groups and deplores the fact that certain deviations are being made which place the problem of neurosis on too superficial a level, leading to failure in the solution of the problem.

Doctor Kubie also discusses the rigid training that the student of psychoanalysis must undergo to achieve recognition as a qualified analyst.

All in all this is a worthwhile book. A more informative book in this field has not been written. The individual who is interested in obtaining true information about a science that has frequently been misrepresented and misinterpreted will find adequate and concrete answers in this book.

M.F.G.

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MEDICAL TREATMENT OF BLEEDING DUODENAL ULCER*

A. N. FERGUSON, M.D.

FORT WAYNE

The Author:

Doctor Ferguson is a 1929 graduate of Rush Medical College of the University of Chicago, and holds the B.S., M.S., Ph.D. and M.D. degrees. He is a Fellow of the American College of Physicians, and is in private practice of internal medicine and diagnosis, and is senior physician in internal medicine at the Duemling Clinic in Fort Wayne.

IN DISCUSSING the treatment of bleeding duodenal ulcer, it must first be recognized that there are various degrees of hemorrhage. Many patients have severe bleeding, the so-called massive hemorrhage, but in others the bleeding is moderate and occasionally it is relatively slight. This necessitates individualization of each patient. Principles of therapy can be formulated but the amount of treatment used for each case depends on the severity of the bleeding. The following case histories illustrate differences in the rapidity and amount of hemorrhage.

CASE I

Mr. C. E., age 48, had had indigestion for about eight months, beginning in March, 1948, with the time relationships of peptic ulcer but with normal x-ray findings. He had been given a powder containing Metamucil and calcium carbonate, equal parts, one teaspoonful at 10:00 A.M., at 3:30 P.M., and at 9:30 P.M., which he took intermittently for a short time and then discontinued.

On November 20, 1948, while on a business trip, he felt a little dizzy and faint. Then he noticed that his stools were black. He began to take the powder irregularly, also some Pepto-Bismol. In about four days his stools were normal color again but he continued to be weak. He came in to see the writer on December 4, 1948, two weeks after the onset of hemorrhage, and approximately ten days after the bleeding had stopped.

On examination he appeared pale. The hemoglobin was 43 percent, and the red blood count 2,700,000. Hospitalization was urged but he insisted on continuing his work and contended that he was recovering from his acute condition. After considerable discussion he was placed on careful ulcer management, even waking himself during the night to take powders. He followed this careful program and made an uneventful recovery although the improvement in his blood count was slow. Weekly counts showed some improvement but it

* Presented at the centennial session of the Indiana State Medical Association, at Indianapolis, on September 28, 1949.

was not until February 5, 1949, two months after the beginning of treatment, that his count had returned to normal, when his hemoglobin was 85 percent and red blood count 4,700,000. His recovery probably would have been more rapid on bed rest in the hospital. This is a patient, then, with a hemorrhage, who continued his work and was treated entirely as an ambulatory patient.

CASE II

Another hemorrhage, relatively mild but with hospitalization, is illustrated by the following patient. Mr. J. E. was admitted to the hospital on December 13, 1948. On December 6 he had noticed tar colored stools and again on December 7 and 8. On December 9 his stools were green. He was not especially alarmed and consulted his family physician by phone. Eventually blood counts were done and he was referred to the hospital for treatment. He stated that for about a month previously he had had a sour stomach for which he had taken soda. Fourteen years before he had had a massive hemorrhage diagnosed as duodenal ulcer and he was in the hospital for six weeks. After that he had had no significant distress until this last episode.

Physical examination showed an obese man weighing 200 pounds, slightly pale but not acutely ill. Blood pressure was 122/84, pulse rate 60, and all other findings normal. Laboratory study showed hemoglobin 76 percent, and red blood count 3,660,000.

He was placed on a program of liquid Gelusil—2 teaspoonfuls in ⅓ glass of water at 7:00, 9:00, and 11:00 A.M.; 1:00, 2:00, 4:00, 5:00, 7:00, 9:00, and 10:00 P.M.; and calcium carbonate, 4 grams in ½ glass water, at 1:00 and 3:30 A.M. He was given an ulcer feeding at 8:00, 10:00, and 12:00 A.M.; 2:00, 4:00, 6:00, and 8:00 P.M., a total of seven a day. He did not like milk so that was omitted. He was given bathroom privileges and allowed to be up in his room as desired. On December 27, two weeks after admission, his hemoglobin was 78 percent and red blood count 4,020,000, and he was allowed to go home on a three meal ulcer program. On January 27, 1949, about six weeks after the beginning of treatment, his hemoglobin was 89 percent and red blood count 4,500,000. This patient got along very well on nothing more than a good ulcer program and probably did not need hospitalization.

CASE III

A more typical and perhaps the most common type of hemorrhage is illustrated by the following patient. Mr. G. H., age 32, walked into the office the morning of February 23, 1934. The night before at about midnight he had vomited his supper. A few minutes later he vomited about half a pint of red blood, after which he had two bowel movements, both of which were black. Then he remembered that he had had black stools the day before. He stated that he had never had any abdominal distress of any kind and his bowel movements had been regular. He appeared pale and was perspiring. He was placed in the hospital where his hemoglobin was found to be 61 percent and the red blood count 3,350,000. An ulcer program was begun at once, consisting of milk and cream, three ounces on the hour from 7:00 A.M. to 7:00 P.M. and calcium carbonate, 30 grains, on the half hour from 7:30 A.M. to 7:30 P.M., also at 8:00, 8:30, 9:00, 9:30, and 10:00 P.M. Calcium carbonate, 60 grains, was given at 12:00 midnight, 2:00, 4:00, and 6:00 A.M. A sodium chloride 10 grain tablet was given with each milk feeding. No change in this program was made for eight days except after three days the calcium was reduced after 10:00 P.M. to midnight only, and a Lextron capsule was added to each milk and cream feeding. On the eighth day an ulcer feeding was added. These were gradually increased and recovery was uneventful. He was discharged March 16, three weeks after entering the hospital, with a hemoglobin of 71 percent and red cell count of 4,050,000. This patient recovered, then, on plain accurate ulcer management and represents the most usual patient with bleeding duodenal ulcer.

So far the only treatment used in the illustrative cases has been rather rigid ulcer management. But frequently the hemorrhage is so severe that ulcer therapy alone is not sufficient. In fact, treatment for the hemorrhage itself may become more important than treatment for the ulcer, although treatment for the ulcer should be begun as soon as possible.

CASE IV

Mr. F. P. was admitted to the hospital at 10:30 A.M. on April 5, 1946. For several days he hadn't felt well, was tired and had had to leave the office and go home about 3:30 P.M. On April 3, two days before admission, he began to vomit blood and had done so on several occasions. On admission to the hospital he appeared quite pale but his pulse was full and regular, rate 105. He did not appear to be too seriously ill and his blood counts were somewhat surprising. His hemoglobin was 30 percent and red blood count 1,760,000. A blood transfusion of 500 cc. was given at 12:40 P.M., two hours after admission. Another was given the afternoon of the next day, April 6, and again on the afternoon of April 7, making a total of three transfusions. Shortly after admission an ice bag was placed on the abdomen and he was given pantopon, 1/3 grain. This was repeated in three hours, after which he received pantopon, 1/6 grain, and atropine, 1/120 grain, every four hours for two days. Vitamin C, 200 mgm., was given by hypo twice a day for several days.

Three and a half hours after admission, that is at 2:00 P.M., an ulcer program was begun, consisting of three ounces of milk and cream on the hour and two teaspoonfuls of Amphojel in three ounces of water on the half hour from 7:00 A.M. to 10:00 P.M. He was also given ten grains of sodium chloride with every other milk and cream feeding. After 10:00 P.M., 60 grains of calcium

carbonate in six ounces of water was given every two hours.

Three days after admission ulcer feedings were begun. These were gradually increased and the ulcer program modified. On May 7, approximately one month after entering the hospital, his hemoglobin was 74, and red count 4,210,000. He was discharged May 9, on a three meal ulcer program. This patient illustrates the need for blood transfusions in addition to the ulcer regimen.

CASE V

Not all patients are able to follow an ulcer regimen and the attending physician has to be versatile in various methods of realizing ulcer programs. Mr. F. J., age 61, was diagnosed as having duodenal ulcer in 1946, and placed on management for a time. He was admitted to the hospital as an emergency on January 22, 1949. For a few days he had noticed that his stools were dark. A few hours before admission he had become very weak. There had been no vomiting. On admission his hemoglobin was 78 percent and red cell count 3,710,000. Two days later these were—hemoglobin 52 percent, and red cell count 2,580,000. On that day he was given a transfusion. The following day, January 25, his hemoglobin was 46 percent and red cell count 2,150,000. His general condition, however, was fair and his pulse remained between 88 and 96. He was given another transfusion. After that his blood counts gradually rose. Even so another transfusion was given on January 27, on January 29, and on February 1, making a total of five transfusions.

On admission he was given Vitamin C, 300 mgm. by hypo twice a day, and atropine, 1/200 grain by hypo every eight hours. He was placed on an ulcer program of Amphojel, two teaspoonfuls in three ounces of water, on the hour from 7:00 A.M. to 10:00 P.M., and two ounces of milk and cream on the half hour, 7:30 A.M. to 9:30 P.M. Four teaspoonfuls of Amphojel were given at midnight, 3:00 and 5:00 A.M.

After about 48 hours on this program he stated that he felt extremely tired, was sick all over, refused nursing care and was unable to take milk. Then he vomited a large amount of whitish fluid but with no gross blood. (These symptoms may have been due to azotemia but no blood chemistry was done.) A Levin tube was passed and his stomach lavaged with soda water. In the washings some small brownish particles were recovered, obviously old blood. All returned washings were alkaline. The Levin tube was left in place and he was placed on a four hour program, receiving everything through the tube, as follows: At the beginning of the first hour, Amphojel, two teaspoonfuls in four ounces of water; the second hour, two ounces each of milk, cream, and water, making a total of six ounces; the third hour, twenty grains of soda bicarbonate; and on the fourth hour the stomach contents were aspirated, measured, tested for acidity with litmus paper, and the stomach lavaged with soda water until the washings were alkaline to litmus. This program was repeated every four hours with minor changes for about thirty-six hours. The four hour aspirations showed that the acidity was well controlled. After the first two aspirations no old blood was present. He improved generally and the tube was removed. He was again placed on the original program except that Gelusil was substituted for Amphojel to please the patient's taste. Ulcer feedings were begun, the first one being Cream of Wheat, ten hours after the tube was removed. He gradually improved and his program was modified accordingly. He was discharged from the hospital February 13, twenty days after admission, on a three meal ulcer program. At that time his red count was 3,920,000. This patient's pulse did not go above one hundred and he was not in shock at any time. His gastric acidity was controlled, blood counts watched and transfusions given accordingly, all of which accounted for his recovery.

CASE VI

Massive, relatively sudden hemorrhage from a bleeding duodenal ulcer can produce shock just as any other hemorrhage. When this occurs, quick action is demanded. Mr. W. L. was seen about the middle of the afternoon on November 3, 1934, complaining of extreme weakness. Inquiry revealed that he had been passing tarry stools. He looked pale. Since he had eaten no lunch he was x-rayed late that afternoon, after which arrangements were made to put him into the hospital. Shortly after entering he vomited a large amount of blood mixed with barium. His blood pressure dropped to ninety-four systolic and fifty diastolic, blood count was 2,660,000; hemoglobin fifty-two percent; pulse rate rose to one hundred and twenty and he went into shock. One of the supervising nurses was a universal donor and she offered blood for an immediate transfusion. This was given within an hour after the vomiting and is credited with saving the patient's life. He was almost unconscious and appeared moribund before receiving the transfusion, but improved immediately afterwards. Two hours later he was given physiological salt solution, 500 cc. by hypodermoclysis. This was repeated twice at four hour intervals. The following day he received the same three times at approximately four hour intervals, making a total of six hypodermoclyses.

Thromboplastin was given intramuscularly twice daily for two days. Ten cc. of autogenous blood was given the first day. Morphine sulphate, grains 1/6, and atropine, 1/150 grain, were given every six hours for two days, then gradually decreased. About ten hours after the transfusion an ulcer program was started of milk and cream on the hour and calcium carbonate, grains 30, on the half hour, from 7:00 A.M. to 7:30 P.M., with calcium during the night, similar to that given to Mr. G. H. Ulcer feedings were begun on November 12, eight days

after entering the hospital. These were gradually increased and he improved rapidly. On November 22, nineteen days after entering the hospital, his hemoglobin was 79 percent and red blood count 4,150,000. A quick transfusion then, followed by several hypodermoclyses and an early ulcer program prevented a fatal outcome in this patient.

CASE VII

A bleeding duodenal ulcer can be fatal, as shown by the following patient who was seen several years ago. Mrs. C. P., age 63, was found to have an uncomplicated duodenal ulcer of six years duration. She was placed on management, became symptom-free in six weeks and continued on modified management for approximately six months. Thereafter she remained in excellent health for five years. Then she awoke one morning nauseated and vomited blood, after which a copious tarry bowel movement occurred. She was placed in the hospital where she continued to be nauseated and vomited more blood on several occasions. Treatment consisted of nothing whatever by mouth and three blood transfusions in thirty-six hours. At that time she was extremely pale, very restless, the pulse was imperceptible and she was almost moribund. Continuous aspiration of the stomach was begun and more transfusions arranged but she died three hours later. This patient illustrates that in massive hemorrhage transfusions alone may not be sufficient.

These illustrative cases indicate the necessity for individualization of patients with bleeding duodenal ulcer. One patient with rather severe hemorrhage recovered on ambulatory treatment and while he continued at work. Another really did not need hospitalization. The majority, however, require emergency treatment and observation. In general, in the author's opinion, patients who have tarry stools alone have less severe hemorrhage than patients who also vomit blood. In all certain principles are designed to control the hemorrhage and treat the peptic ulcer. The two are equally important and should be applied simultaneously. Both should be begun at once.

SURGICAL INTERVENTION

With massive hemorrhage, emergency surgery is frequently considered.[1] The writer is of the opinion that such surgery is seldom necessary and is in accord with Dr. Bockus[2] of Philadelphia who makes the following points: First, a definite preoperative diagnosis is difficult to make. Second, the patient who has just had a severe hemorrhage is a poor operative risk. Third, recovery is the rule without operation. Dr. Bockus states: "After reviewing my experience in seventy-two cases of massive hemorrhage, I am not convinced that the mortality could have been reduced by the more frequent use of early surgery. Since the death rate following conservative measures is comparatively low, every patient should be treated for a brief period by conservative measures. If the hemorrhage has been severe and normal blood volume cannot be maintained, and all clinical signs point toward a continuation of the bleeding, surgery should be seriously considered. If the patient gives a long history of ulcer-like symptoms and is beyond the age of fifty years, surgical intervention may offer the better chance of recovery. Neither massiveness of the hemorrhage nor the low level of the blood count on admission constitutes an indication for operation without a trial on conservative treatment." Dr. Amendola[3] stated these same views recently.

MEDICAL MANAGEMENT

The medical management of a bleeding duodenal ulcer may be tabulated as follows:

A—Treatment for Hemorrhage.
1. Transfusions:
   Early—to combat acute hemorrhage;
   Late—to hasten recovery.
2. To Aid Coagulation:
   Vitamin C;
   Vitamin K;
   Autogenous blood.
3. Ice Bag to the Abdomen.
4. Opiates and Sedatives.
5. Vitamins, Iron and Liver.

B—Treatment for Ulcer
(Control of gastric acidity):
1. Alkalies.
2. Frequent Feedings — Milk and Cream, Food.
3. Aspiration—Intermittent, Continuous.
4. Atropine.
5. Sedatives—Opiates, Barbiturates.

C—After Recovery—Treatment for Chronic Peptic Ulcer.

Transfusions may or may not be needed, often depending on the judgment of the physician. Certainly they should be given when the patient's systolic blood pressure drops to below 100, the pulse rate rises above 120, and the patient is in shock. A hemoglobin below 50 percent and red blood count below 2,500,000 is also an indication for transfusions. Ordinarily a patient may be considered out of danger when his hemoglobin stays above 70 percent and the red count above 3,500,000.

Coagulants should be given to all patients in order to be safe in this respect. Subclinical vitamin deficiencies are hard to detect. Further an abundance of Vitamin C particularly may help in restoring the blood picture. Vitamin K should be given. In desperate situations such substances as thromboplastin may be of value and autogenous blood can be used intramuscularly.

An ice bag to the abdomen does little more than help to keep the patient quiet, which is of some value.

Opiates, especially morphine and its derivatives such as pantopon, are time-honored and indispensable. They should be used freely and in sufficient dosage. Morphine, 1/6 grain, and atropine, 1/150

grain, can be given every four to six hours for several doses. Later, sedatives such as phenobarbital make the patient more comfortable and are of help generally.

During convalescence considerable protein in the diet, multiple vitamins, iron, and liver by mouth, aid in blood formation and restoration.

In the author's opinion, the most important point in the treatment of a bleeding duodenal ulcer is the treatment of the ulcer itself. This should be begun immediately, without any period of starvation, and while arrangements are being made for transfusions if these are necessary. The cardinal point in the treatment of the ulcer is control of the acid gastric secretion. Such secretion digests any clot that forms in the crater of the ulcer and thus favors continuation of the bleeding.[4] This control of the acid gastric secretion may be done in a number of ways and various programs have been recommended. If vomiting interferes with the institution of such a program, other measures to be described later may be relied upon for a few hours or continuous aspiration may be begun.

The simplest way to control acid gastric secretion is by the use of alkalies. Many are available and it makes little difference which one is used as long as enough is given to keep the stomach contents alkaline, with one exception. With anemia, patients are more prone to develop alkalosis, consequently sodium bicarbonate should be used with caution. More preferable are calcium carbonate and the aluminum hydroxide preparations. Judgment is required in their use. The basic program used by the writer is a modified Sippy program recommended by Palmer.[5] Thirty grains of calcium carbonate in three ounces of water are given hourly on the half hour from 7:30 A.M. to 9:30 P.M. and 60 grains every two hours during the remainder of the night. This basic program can be modified to meet individual patients' needs. As improvement occurs the night doses are gradually reduced. Magnesium carbonate, 30 grains, or milk of magnesia should be substituted for a sufficient number of the calcium carbonate powders, usually one to five, to produce a bowel movement daily.

Feedings should be begun as soon as possible. The traditional one is milk and cream, three ounces on the hour from 7:00 A.M. to 10:00 P.M. Most patients can take this but often considerable ingenuity is needed. Some patients just won't take milk. The patient himself has to be considered and substitutes made. Additional ulcer feeding, particularly Cream of Wheat, can be begun soon. These are best tolerated when begun twice a day and gradually increased to six a day. The type of food is not so important as long as it is relatively soft, small in quantity, and given at frequent intervals. After six feedings a day are taken for several days a three meal ulcer program may be started, usually three to four weeks after the beginning of treatment.

A Levin tube is frequently of great help. In patients who are unable to take things by mouth, this tube may be passed through the nose and left in place. Aspiration of the stomach may be made continuously but in the author's experience it is better to aspirate intermittently every four hours, with lavage of the stomach, using weak soda bicarbonate solution and continuing until the solution returns alkaline to litmus paper. Alkalies, such as Amphojel in two to four ounces of water, are administered through the tube at stated intervals, at least every hour, and that remaining at the end of each four hours removed by the aspiration. This Levin tube can also be used to determine whether or not the acidity is being controlled at any time. The tube is simply put in place, aspirations made at the times desired, and the acidity tested.

Atropine is of help in reducing the gastric secretions. Individuals vary in their response to this drug. It can be begun as grains 1/150 every four to six hours by hypo and changed according to the patient's tolerance, manifested particularly by dryness of the mouth. Opiates and sedatives are necessary in practically every case. On admission, morphine is given for a time, after which sedatives such as phenobarbital are of help. A mixture containing sodium bromide, 4 drams in elixir of phenobarbital to make six ounces, may be used, one teaspoonful before each meal and at bedtime. This mild sedation may be continued for a long time.

After the patient has recovered and is discharged from the hospital, it must be remembered that he still has a chronic duodenal ulcer. He should be kept on a careful ulcer program for at least three months after leaving the hospital, and then given a modified ulcer program to be followed for at least another year. Peptic ulcer is a chronic disease and is subject to exacerbations and remissions which may occur at any time during the remainder of the patient's life.

CONCLUSIONS

1. A patient with a bleeding duodenal ulcer should be given individualized treatment. Principles of therapy can be formulated but the amount of treatment used in each case depends on the rapidity and severity of the hemorrhage.
2. Treatment should be directed toward two main goals which are equally important and both of which should be started at once. These are control of the hemorrhage and treatment of the ulcer itself. (Control of the acid gastric secretion.)
3. Measures to accomplish both of the above have been presented in outline form with comments.

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SURGICAL TREATMENT OF BLEEDING DUODENAL ULCER*

HAROLD D. CAYLOR, M.D.

BLUFFTON

The Author:

Doctor Caylor received his B.S. degree from the University of Chicago in 1916, his M.D. degree from Rush Medical College, Chicago, in 1922, and his M.S. from the Mayo Foundation, University of Minnesota in 1927. He served as assistant and associate in surgical pathology and a special student in experimental surgery at the Mayo Foundation, Mayo Clinic from 1924 to 1929. He is now general surgeon at the Caylor-Nickel Clinic, Clinic Hospital. He is a diplomate of the American Board of Surgery.

OUR COLLABORATOR in this discussion has already given you the salient features of the medical treatment of bleeding duodenal ulcer. We plan to consider carefully in this study with our colleagues in internal medicine the problems involved in surgical treatment of bleeding duodenal ulcer patients and we accept this as a joint responsibility.

Last year Dr. I. S. Ravdin, speaking before this association, said "It is important therefore that each patient be seen frequently by both internist and surgeon and that they share responsibility and pool their experiences, judgment, and therapeutic resources."[1] To be avoided is the internist who maintains medical regimen until a patient with a bleeding duodenal ulcer is exsanguinated and moribund and then calls in a surgeon, as well as the surgeon who aggressively attacks every bleeding duodenal ulcer patient with some operative procedure without definite indications for such therapy other than the patient's or his relative's consent.

INDICATIONS FOR SURGICAL THERAPY

In our experience by far the greatest number of bleeding peptic ulcer patients are controlled by medical management. After the establishment as best we can of the diagnosis in these cases, failure of medical management is one of the foremost indications for surgical therapy. If operative therapy seems mandatory, the earlier the patient can be prepared and the procedure completed, the better the results and the lower the mortality rate.

Severe exsanguinating hemorrhages which do not respond to restorative measures, such as repeated transfusions of whole blood, oxygen and anti-shock therapy after a reasonable period of time, usually of not more than 24 hours, are an indication that this patient with a bleeding duodenal ulcer is a candidate for surgical therapy.[2, 3] We consider as a severe hemorrhage one which depresses the erythrocyte count to 2.0 million or below.[4]

Recurring hemorrhages, particularly massive hemorrhages from a bleeding duodenal ulcer in an older individual, is per se an indication for surgical therapy.[2] Hematemesis is a much more fearful sign than melena.[2] Severe or recurring hemorrhages may start an irreversible process in the human organism which begins as acute circulatory failure and runs the gamut of cerebral anemia, damage to the vasoconstrictor center in the medulla, perhaps acute coronary insufficiency with anginal syndrome, and finally diminished glomerular filtration and a rise of blood urea nitrogen and other products of metabolism. According to Amendola, the anemia following severe hemorrhage is not as important a factor in the rise of blood urea nitrogen as the absorption of the digested blood proteins and the prolonged fall in blood pressure; this combination produces azotemia of longer duration. A careful series of observations on the rise and fall of blood urea nitrogen in gastrointestinal hemorrhage is valuable, for usually the azotemia remains elevated for 24 to 36 hours following a single episode of bleeding; however, a sustained rise of blood urea nitrogen in the absence of severe dehydration or pre-existing kidney lesions is usually indicative of persistent bleeding.

Another indication for surgical treatment is a bleeding duodenal ulcer with obstruction or perforation. Gray, commenting on these combinations, observed that complicated duodenal ulcers are the ones that usually require surgery and the most common complications are obstruction, hemorrhage, and a tendency to perforation. With obstruction, partial or complete, a potent route of medical treatment is blocked or ineffective and the deterioration of the patient is more rapid.

Hemorrhage and perforation may occur in asso-

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ciation in spite of a widespread impression that such complications do not exist together. These call for surgical therapy.[3]

Special attention should be called to the importance of severe gastrointestinal hemorrhage in a person aged 55 years and older.[2, 3, 4, 5] In this group the mortality rate increases remarkably and a fatal outcome obtains in approximately one-third of the cases. In this group, especially, surgical therapy must supplant unsatisfactory medical management early if the patient's life is to be saved before exsanguination has robbed the victim of his recuperative power. The risk of lethal hemorrhage is much less in a younger person, but above 45 years a bleeding ulcer likely has been present longer, has more fibrosis and penetration of its base and inflexibility of the crater, and is less likely to stop bleeding spontaneously.

Although age is not a definite criterion for any one type of therapy, in this disorder most of the fatal cases occur in the group aged 45 years and more, so here the most aggressive type of therapy, medical or surgical, must be instituted.

There is a tendency among all of us, internists and surgeons alike, to waste time trying to replace a blood loss that is continuing and the decision to operate or not is most difficult to make, but with few exceptions surgical therapy should not be instituted without a preliminary trial of restorative measures and expectant treatment.[6]

PREPARATION FOR SURGERY

Once the decision has been made to institute surgical treatment massive replacement of the blood loss is necessary to carry this very ill patient through the procedure. Continuous transfusion of whole blood through two or more portals is instituted and maintained so long as the systolic pressure is below 90 or the pulse above 130 or both.[4] A blood bank with the patient's type of blood in adequate supply (2000-3000 cc.) is a must for this type of surgery. Barbiturates or morphia are given to control restlessness. Oxygen is supplied as needed.

Our choice of anesthetic in these cases is cyclopropane and oxygen, or nitrous oxide oxygen-ether, whichever your anesthetist can best administer and the patient best tolerates. We have a distinct aversion to spinal anesthesia in patients who have been in shock or are in a condition where severe shock is impending.

SURGICAL PROCEDURES

The operation of choice in bleeding duodenal ulcer is partial gastrectomy, including excision of the ulcer.[2, 6] Since most bleeding duodenal ulcers occur on the posterior wall of the duodenum and may be relatively inaccessible, in certain parcularly urgent cases it may be wise to do an immediate duodenotomy and control the bleeding by a few deep silk sutures in the ulcer base and then proceed with a more leisurely partial gastrectomy. On other occasions, particularly with a penetrating type of ulcer which may have burrowed deeply into the pancreas, it may be necessary to leave the base of the ulcer and mobilize the duodenum around it sufficiently to be able to close the distal end of the duodenum in an adequate fashion.

Occasionally the source of the bleeding cannot be found without opening the duodenum and stomach, irrigating them with saline solution and searching diligently for the bleeding point. If the bleeding point cannot be found we advise closure of the duodenotomy and gastrotomy without resection.

Palliative procedures such as suture of ulcer bed or ligation of vessels supplying the ulcer are inadequate surgery and are to be avoided. The only palliative procedure we do recommend is a simple high jejunostomy under local anesthetic in patients who, when they are first seen, have been bleeding continuously or repeatedly for several days. Such patients are notoriously poor surgical risks; the high jejunostomy may be of value for feeding purposes.

POSTOPERATIVE CARE OF GASTRIC RESECTION FOR BLEEDING DUODENAL ULCER

As soon as the patient is returned to bed, he is immediately placed in an oxygen tent and a Levin tube inserted through the nose, with Wangensteen continuous suction. A fluid balance sheet is started in the chart and accurate account is kept of all intake and output in graph form, so when the fluid balance becomes positive one then knows it is proper to remove the tube and allow fluids by mouth. Transfusions of whole blood as indicated by clinical and laboratory data are given, as well as glucose, protein solution and a saline by venoclysis. Deep breathing is encouraged by CO_2 inhalations, if necessary, and sedation as indicated is maintained. Within the first twelve hours the patient is encouraged to swing his feet on the side of the bed, and to stand on his feet and walk around the bed within the first twenty-four hours. As soon as a positive fluid balance is obtained, and this usually means the edema at the stoma has subsided, fluids by mouth and then soft diet is instituted. Frequent blood chemistry evaluations are obtained to guide intravenous and oral therapy.

Because of exsanguination, healing processes are likely to be delayed. Sutures, therefore, are not removed as early as in other laparotomies. Eventration of the wound is not an uncommon postoperative complication.

DISCUSSION

The problem of bleeding duodenal ulcer requires the greatest skill, knowledge, judgment and cooperation of the internist and surgeon. In order to give priority to the patient's welfare and return to health, each case must be studied carefully and observed frequently. This is no place for obstinancy by surgeon or internist for any one concept of

therapy which might be detrimental to the patient's welfare.[1] Such cooperation is necessary in order to select from the large number of bleeding duodenal ulcer patients the relatively small group who might be saved by emergency surgical intervention.

SUMMARY

These observations include an analysis of the indications for operation for bleeding duodenal ulcer. Surgical preparation of the patient is discussed and partial gastrectomy with excision of the ulcer is the suggested operation of choice. Importance of close cooperation between surgeon and internist in the case of bleeding duodenal ulcer patients is emphasized.

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TREATMENT OF CARDIAC ARREST BY CARDIAC MASSAGE

J. C. Fleischer, M.D.

INDIANA HARBOR

ACUTE cessation of cardiac activity can occur during any type of anesthetic or any type of surgical procedure, be it major or minor. Several causes may be considered:[1]

(1) Shock due to prolonged surgery.
(2) Reflex arrest due to vago-vagal stimulation.
(3) Stimulation of the carotid sinus.
(4) Overdosage of anesthetic agents.
(5) Ventricular fibrillation.
(6) Acute oxygen want, such as may be caused by lack of oxygen in the respired atmosphere, or by one of the respiratory emergencies outlined above.

The signs and symptoms of cardiac arrest are conspicuous, and should be watched for under all anesthetics:

(1) Absence of pulse in any artery.
(2) Cessation of heart beats.
(3) Cessation of blood pressure.
(4) Cessation of wound bleeding.

Treatment of cardiac arrest must be instituted immediately if there is to be any hope of revival. Authors differ as to the limit of time which is available for restoring heart function. The optimum time limit certainly cannot exceed five or six minutes if successful restoration of all functions is to be obtained. This is particularly necessary in order to avoid damage to the brain tissues which suffer most rapidly from anoxia. Artificial respiration should be instituted and maintained throughout the period of revival, as this will maintain the oxygen level of the blood, and so decrease any possibility of damage to the brain tissue while the cardiac arrest is being corrected.

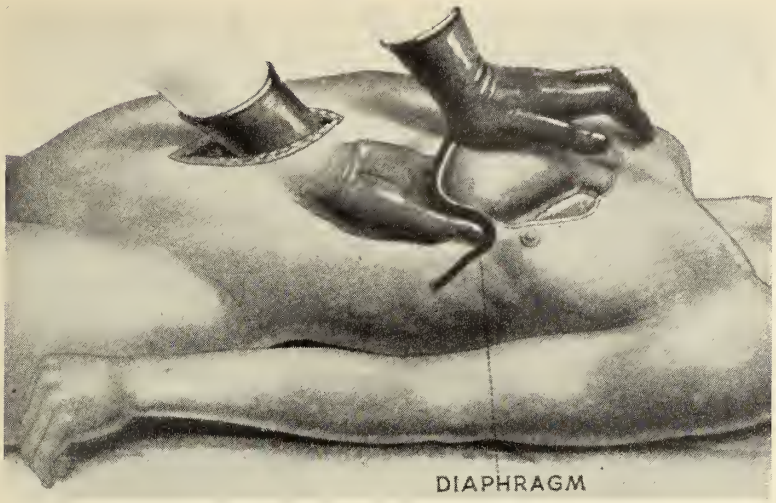
The procedures of restoration are as follows:

(a) Trendelenburg's position of the body.

(b) If there is an abdominal incision, massage of the heart under the diaphragm, maintaining pressure on the precordium with the base of the left hand. Effective intermittent pressure can be exerted on the ventricles by the pumps of the right hand beneath the diaphragm, approximating normal cardiac rate. If the heart is going to respond, it will do so in a matter of minutes. The beats then strengthen quickly, and soon reach a normal rhythm and force. There certainly can be no greater reward in surgery, regardless of time or extent, than to see a patient's life return to being before one's very eyes.

When the operator is not satisfied that he is compressing the ventricles effectively, because of a deformed or rigid costal margin, or if no response to the standard method has been obtained after a minute and a half, Nicholson's method may be adopted. This consists of making a buttonhole incision immediately behind the base of the sternum between the attachment of the two sides of the diaphragm. With the thumb of the right hand inserted through the opening, the heart then can be compressed between the thumb and the fingers beneath the diaphragm. While this is going on, introduction of stimulants through the circulation may be resorted to, such as epinephrine, coramine and other analeptics.

Figure 1



Standard method of performing cardiac massage.

In the event that an abdominal incision is not present at the time of surgery, one should be made immediately in as short a period of time as possible by one sweeping stroke in the midline just under the xiphisternum and should be large enough to admit the hand. Then cardiac massage may be instituted immediately.

If the cardiac arrest is allowed to persist for more than five or six minutes, the probability of irreparable damage to the brain is so great that further efforts may be regarded as useless.

Some authors report cases in which the time period elapsed has been twelve minutes or longer, but in these cases there has been severe damage to the brain tissue, and the patient has not successfully overcome the damage to the brain tissue caused by the anoxia.

If the patient recovers from the cardiac arrest, and the condition seems to warrant continuation of the surgical procedure, then the operation may be continued under anesthesia. If, however, the condition of the patient is not good, continued stimulation by means of intravenous fluids, blood, saline, and analeptics may be resorted to until the condition improves sufficiently to finish the operation.

Bailey[2] reports a case of a boy, age 12, who had cardiac arrest overcome after twelve minutes. This patient suffered visual and other disturbances of the central nervous system, but these ill effects had disappeared after six months.

Easton[3] reports a case of a woman, aged 25, whose heart stopped during chloroform anesthesia for childbirth. He performed cardiac massage by Nicholson's method after making an incision with an unsterilized scalpel, with unwashed hands. She recovered completely, the abdominal wall being sutured several hours after recovery, with administration of general anesthesia.

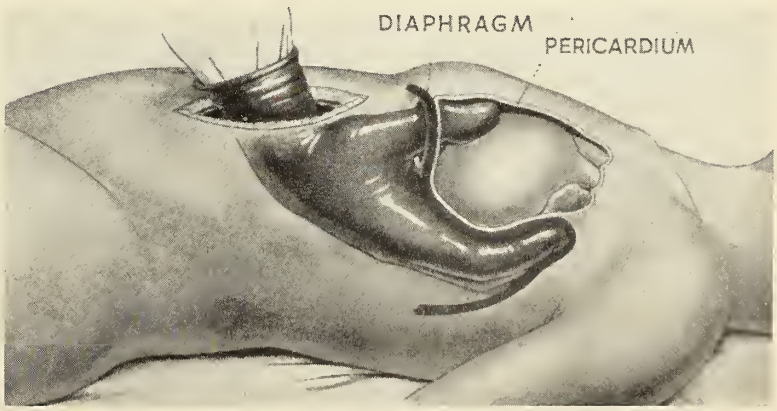
Grimshaw's patient[4] was a 61-year-old woman whose heart stopped during pentothal anesthesia. Cardiac massage three minutes later led to complete recovery.

These and the following case reports prove that cardiac massage can and will bring back life to those patients whose hearts have ceased to beat while under anesthesia, of no matter what type.

Case No. 1—A white woman, age 46 years, was scheduled for cholecystectomy. She was premedicated with morphine, grains 1/6, and scopolamine, grains 1/250. She had a damaged heart and had been treated prior to surgery until it was felt that she could tolerate the operation. Her heart at the time of surgery was in good condition.

Induction was with cyclopropane and oxygen. The procedure was normal during the first stages of the operation. At the time the patient's gallbladder was being freed from its bed, cardiac arrest occurred. About two minutes later it was noticed that the blood pressure had dropped to zero and pulsation of the vessels was absent. Surgical procedure was halted immediately, and the patient put in Trendelenburg's position. An

Figure 2



Nicholson's method of performing cardiac massage.

ampul of epinephrine was administered intravenously, but with no results.

Cardiac massage was started about three minutes after the cardiac arrest occurred. After massaging for one minute, the first pulsation in the heart muscle was felt. Five and a half minutes after the initial arrest occurred, pulsation was normal and the condition apparently corrected. She was given oxygen and a blood transfusion.

Her condition appeared good, so the operation was completed in the least possible time. The patient remained comatose for two days following surgery, during which time she responded very sluggishly to all forms of stimulation. Hydration was maintained by use of blood transfusions, intravenous saline with glucose, and intravenous water with glucose. Sedation at this time was kept at an absolute minimum.

After the second day the patient made an uneventful recovery. She complained of some blurring of vision for the first two days after she emerged from the coma, but this was attributed to the surgical and anesthesia shock. Her vision returned to normal after two days, and her recovery thereafter was uneventful. She was allowed out of bed on the tenth day, and was discharged from the hospital nineteen days after surgery, ambulatory, and in apparently good condition. Repeated examination for six months after surgery showed no evidence of any damage which might have occurred during the time of cardiac arrest.

Case No. 2—A male negro, 35 years of age, entered the hospital through the emergency room with a gunshot wound of the abdomen. He was immediately taken to surgery and prepared for operation. His premedication consisted of ⅙ grain of morphine and 1/200 grain of scopolamine.

The bullet entered the abdomen just to the left of the midline in a posterior course. On opening the abdomen with a right paramedian incision, it was found that the bullet completely severed and macerated the pylorus and descending loop of the duodenum. The bullet ricocheted off the vertebral column and passed upward through the large right lobe of the liver, causing a laceration large enough to permit the entrance of the operator's entire hand. The bullet emerged from the dome of the right lobe of the liver and lodged under the skin adjacent to the tenth rib in the right lumbar region.

The lacerated ends of the stomach and duodenum were sutured, and the posterior gastro-enterostomy was started. Hemorrhage from the liver at this time was controlled by pressure packs with large laparotomy sponges, other methods of hemostasis such as sutures and oxygel gauze having failed.

At the onset of the gastro-enterostomy, cardiac arrest was noted. One minute later cardiac massage was instituted. Just prior to this two pints of blood had been administered to replace blood loss from the lacerated liver. The heart began beating within a half minute after massage was instituted, and within a minute and a half had returned to normal. The gastro-enterostomy was then completed and the patient returned to his bed in the shortest possible time.

He was given oxygen, whole blood and intravenous saline throughout the first twenty-four hours, and his condition remained critical. Nasal oxygen was also administered continuously. He was treated with intravenous fluids, Wangensteen's suction, and colon tube, for the first five days. During this time his condition was watched very closely. Blood loss from the incision was moderate, and was replaced by transfusions. Antibiotics were administered continuously to control infection, and sedation used as needed. Oxygen was discontinued on the fourth day and the Wangensteen suction on the seventh day. He made a good recovery thereafter, apparently having no residual ill effects from the cardiac arrest.

SUMMARY

Cardiac arrest is perhaps the most severe hazard which may confront the surgeon, no matter what the field in which he is practicing. It can occur in any patient, with any anesthetic or anesthetist, during any operation, emergency or otherwise. The signs and symptoms are easily discernible, especially when the surgeon and anesthetist are alert and on the lookout for them.

Early recognition and treatment are of the utmost importance, if the condition is to be combatted effectively. Cardiac massage is the most direct method, and should be instituted as early as possible. If there is no abdominal incision present when the heart failure occurs, one should be made immediately, and massage started. Artificial respiration should be continuous, until the heart beat has been restored to normal.

With nothing to lose and much to gain, certainly it is worth the while of the surgeon to attempt to restore his dead patient to life. It is a great relief and a source of much satisfaction to see one's patient come back to life after being in the region of the great beyond.

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INTRAVENOUS PROCAINE

NEIL DAVIS, M.D. MARY KARP, M.D.*

CHICAGO

PROCAINE was first synthesized by Einhorn in 1905. It soon became and has remained the most widely used of all local anesthetics. In spinal anesthesia its preeminence is challenged by other preparations but in the field of infiltration anesthesia it has no contender. This fact has blinded the profession to the many other uses of procaine.

In 1908 the Spanish physician Goyanes[1] injected procaine into an artery in an attempt to secure regional anesthesia of an extremity. In 1909 Bier[2] secured anesthesia by injecting procaine into a vein distal to a tourniquet, thereby trapping the drug in that portion of the extremity requiring surgery. Soon thereafter vasoconstrictors were added to procaine and poor results followed. Physicians became cautious about its use and the intravenous route was given up until in 1935 when Leriche and Fontaine[3] advocated the use of intravenous procaine in the treatment of arteritis obliterans.

Following this revival of the intravenous route, its safety was soon attested and the many possibilities of an old therapeutic agent with a new application were recognized. Today its literature is rapidly growing as men report thousands of applications of intravenous procaine. The involved pharmacology is rather simple. Areas of inflammation and trauma are known to have increased vascular beds, with greatly increased permeability of their capillaries. This increased permeability permits sufficient quantities of circulating procaine to accumulate in the abnormal area to produce anesthesia. Procaine administered by the intravenous route has been found to be eight times more concentrated in the traumatized or inflamed tissue than in the normal tissue.

In 1939 Lundy[4] was asked to see a case of severe pruritis caused by prolonged jaundice. He advised the use of procaine intravenously and the results were very gratifying. With the outbreak of the war Tovell[5] used procaine intravenously to give adequate analgesia for the transportation of the battle casualties. It was then applied to the treatment of burns and painful dressings of burns. Gordon[6] reports the use of this agent in burns in civilian practice. Ten minutes after infusion begins, treatment of dressings can be begun. No morphine or other sedatives are required and relief of pain is continued for about six hours. It produces sufficient analgesia for the reduction of fractures and dislocations. When Peterson[7] applied this treatment to osteoarthritis he reported "all patients showed marked relaxation, increased coordination, and increased mobility and use of the extremities." Favorable results have been reported by the same author in the treatment of poliomyelitis and congenital spastics. In reporting a case of Parkinson's disease he writes, "The results of this treatment have been almost complete absence of tremors and improvement in coordination. No relapse has been noted in the three months following the onset of treatment." Ravinia[8] has used intravenous procaine in the treatment of herpes zoster, with an immediate disappearance of pain, although there was no change in the progress of the disease.

Recently Wolfson[9] has revived the early method of injection of procaine distal to a tourniquet. He reports forty cases which were satisfactorily anesthetized to perform the proposed surgery, which included debridement and repair of lacerations, closed reductions of fractures, incision and drainage, and excision of ganglia and tumors. He reports, "An unanticipated good result with this method was obtained in six children, aged 7 to 12. The suggestion is made that in traumatic surgery of the extremities in children who have recently eaten, this method may prove very useful since general anesthesia is so often associated with disturbing emesis and the degree of cooperation necessary for other forms of regional anesthesia cannot be obtained."

At times cyclopropane is known to produce cardiac arrhythmia. Epinephrine greatly increased this hazard and may produce ventricular fibrillation. In 1940 Burstein[10] studied this reaction in dogs and found that the arrhythmia could be controlled by intravenous procaine. During the war this author was an anesthesiologist in a military hospital in Europe in which a great deal of chest surgery was done. He found that when opening the pericardium for the removal of foreign bodies or the repair of wounds of the heart, the myocardium became irritable and often fibrillated. At first it was found that painting the cardiac wall with procaine produced an improvement in the rhythm but later an infusion of procaine produced far superior results and the surgeon could proceed without fear of cardiac arrest upon manipulation. This agent reduces the irritability of the autonomic tissues of the heart and increases the threshold for stimuli necessary to produce fibrillation. The pacemaker returns to the normal sinus node when previously displaced, the refractory period is prolonged and the excitability of the myocardium is diminished. Conduction in the bundle of His is retarded. Burstein also showed by

* From Department of Anesthesia, Wesley Memorial Hospital Division of Surgery, Northwestern University Medical School.

means of the electrocardiograph that derangements in the pacemaker have responded to intravenous procaine. He reports several cases of gross cardiac irregularities which have responded to this therapy.

Experience has shown that cardiac arrhythmia is more easily prevented than controlled after it develops. Therefore, the prophylactic use of procaine before and during surgical procedures has been adopted in patients who present rapid and irregular cardiac rates. Tovell[5] writes "Beneficial effects resulting from the intravenous injection of procaine have been observed. Cardiac action has been stabilized at a normal rate and regular rhythm. The character of the pulse has been improved. Concomitant improvement in patient's general condition has been noticed, not only in elderly, debilitated patients, but also in younger patients having severe cardiac disease, for whom immediate surgical intervention was necessary. It is our belief that this therapy was instrumental in rendering these patients operative and their postoperative courses uneventful."

In 1946, State[11] developed several cases of severe serum sickness following the use of crystallized bovine albumen. Urticaria was persistent but myalgia and arthralgia demanded heroic treatment. Intravenous procaine was resorted to and, much to the surprise of the workers, not only was relief afforded to the muscles and joints but also the urticaria immediately cleared up. Since then many cases of severe anaphylaxis which have resisted epinephrine and the antihistamine preparations have responded to intravenous procaine. Reactions during or following transfusion with poorly matched blood respond to this therapy.

The pharmacology of this reaction is an interesting one; however, the reaction is not fully understood. Peterson[12] points out that the procaine molecule is detoxified by the liver and the first split of the molecule produces para-aminobenzoic acid and diethylamino-ethanol. The latter product has a structural formula very similar to that of benadryl, which may account for its antihistamine activity.

The urological field has been invaded by this agent, not so much in this country as in others. From Argentina[13] comes the report of good results with intravenous procaine in the treatment of anuria in acute glomerulonephritis, such as is seen as complications of scarlet fever and similar acute infections. The author advises that good results can be expected only in early cases and has observed the cessation of intense renal colic when morphine and magnesium sulfate had been unsuccessful. Bressan[14] reports similar success in two cases of anuria after decapsulation of an inflamed kidney failed to restore its function.

The urologist might well remember that the cardiac patient becomes a better surgical risk after treatment with this therapeutic agent. In the postoperative period it has a field of usefulness. In addition to the beneficial effects on the kidney, it lessens the need for morphine, both in dosage and frequency. Many references in the literature attest to this fact.

This therapeutic agent is far from being in an experimental state. It is administered in a .1 percent solution with physiological saline, dextrose, or amigen. Not more than 1,000 cc. of this solution should be infused per hour. Peterson[7] reports that the human body will detoxify 4 mg. of procaine per kilo of body weight in twenty minutes. This he calls a procaine unit and in the absence of liver damage can be administered with perfect safety. If untoward results should occur, they can be counteracted by sodium pentothal. However, a series of 2,000 cases have been reported without resorting to this antidote a single time.

SUMMARY

The literature on intravenous procaine has been reviewed. The usefulness of this agent in analgesia, in cardiac arrhythmia, in serum sickness, and urology has been pointed out. The factors of safety in dosage have been described.

250 E. Superior St.
Chicago 11, Ill.

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THE USE OF A NEW SPIROTHIOBARBITURATE 03620* FOR INTRAVENOUS ANESTHESIA†

A PRELIMINARY REPORT

V. K. Stoelting, M.D., J. P. Graf, M.D., and R. A. Theye, M.D.**

INDIANAPOLIS

A NEW spirothiobarbiturate, 03620, has been used intravenously in fifty patients to provide anesthesia for surgery. The chemistry and pharmacology of this drug and the results obtained in these patients furnish the material for this report.

CHEMISTRY AND PHARMACOLOGY

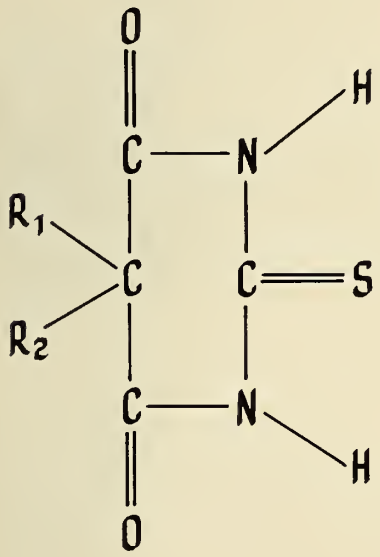
The chemical name of this compound is spiro (2'-ethyl-3', 5'-dimethylcyclopentane) 5, 5-pyrimidine-2-thio-4, 6-dione. It is used as the sodium salt. The following structural formulas demonstrate that 03620 may be considered to be a thiobarbiturate with R_1 and R_2 replaced by a radical with a closed ring.

The duration of action, the median anesthetic dose (AD_{50}), and the median lethal dose (LD_{50}), of 03620 have been determined in rabbits and dogs. These are compared in Table 1 with similar values obtained with thiopental sodium.

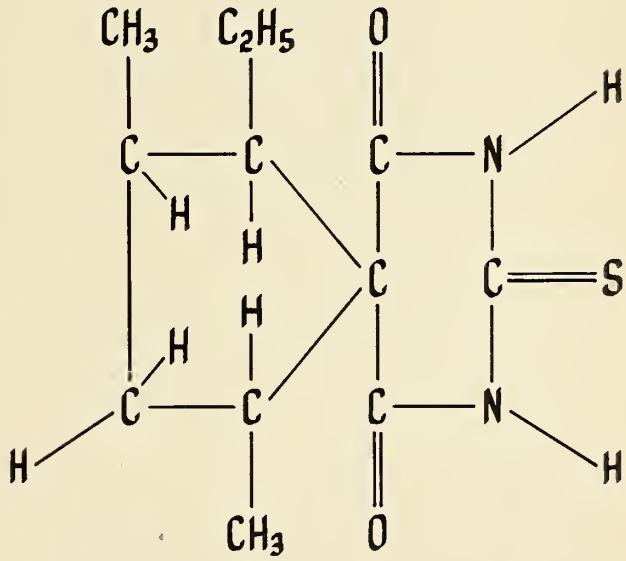
TABLE 1

Barbiturate	Animal	Dose	Duration of Action Minutes	$AD_{50}\pm$S.E.	$LD_{50}\pm$S.E.
		mg. per kg.		mg. per kg.	mg. per kg.
03620	Rabbit	20	28	18.5±1.6	42.0±3.3
	Dog	20	50	18.0±1.0	63.0±4.0
Thiopental Sodium	Rabbit	17.5	55	23.1±1.6	31.1±2.21
	Dog	17.5	60	16.0±0.97	36.4±1.29

ORDINARY THIOBARBITURATE



SPIROTHIOBARBITURATE - 03620



It is noted that the duration of action of 03620 is shorter than that of thiopental sodium in both species tested. This was true even though a larger dose of 03620 was required to produce an equivalent effect.

A group of five dogs received an AD_{50} dose of 03620 intravenously every other day for a period

* Supplied through the courtesy of Eli Lilly Research Laboratories, Indianapolis.

† From the Department of Anesthesiology, Indiana University School of Medicine, Indianapolis.

** Research Fellow in Anesthesiology. Lilly Research Grant. Eli Lilly Research Laboratories, Indianapolis.

of four weeks. During this entire period all of the animals gained weight and showed no loss of response to the drug in either intensity or duration of action. These animals were sacrificed at the conclusion of the four-week study. Necropsy revealed no pathological lesions, grossly or microscopically, in the parenchymatous organs, including the liver.

PRESENT STUDY

Twenty male and 30 female patients were observed in this study. The average age of the group was 32 years with a range of 4 to 76 years. The average weight of the group was 125 pounds with a range of 25 to 242 pounds. The average anesthesia time was 124 minutes with a range of 15 to 270 minutes.

Selection of patients was made only with reference to ordinary precautions taken in the use of any barbiturate. Patients with congestive heart failure or orthopnea were not given the drug.

The types of surgery varied widely, including laminectomy, ilio-tibial band section, open reduction, hip arthrodesis, tendon transplant, cervical dilatation and curettage, perineorrhaphy, vulvectomy, ventral herniorrhaphy, mastoidectomy, skin graft, cystoscopy, nephrectomy, lumbar sympathectomy, salpingo-oophorectomy, and application of radium to the cervix. A few patients received the drug for abdominal and intra-thoracic operations.

In this series of fifty patients, the premedication varied from 8 to 10 mg. of morphine sulfate and .3 to .4 mg. of scopolamine hydrobromide or atropine sulfate. A few patients received 15 mg. or as little as 5 mg. of morphine sulfate. The premedication was given subcutaneously in most instances, one to one and one-half hours prior to operation.

METHOD OF ADMINISTRATION

The drug was administered by the intravenous route. A three-way stopcock inserted between the needle and fluids for intravenous use made this a simple procedure.

The induction of anesthesia with 03620 was accomplished by the administration of quantities sufficient to obtund or eliminate the lid reflex. Nitrous oxide and oxygen were then administered at the flow rate of 4 liters and 2 liters respectively. The carbon dioxide absorption, semi-closed, to and fro or circle filter technique was used for the administration of the inhalation agents.

No endotracheal intubations were attempted with 03620 in this preliminary study. When intubation was indicated, it was accomplished with cyclopropane and ether anesthesia. The patient was then maintained with intravenous 03620, N_2O and O_2. This was done in twelve patients in this series.

In all operations requiring relaxation, Metubine Iodide* was administered intravenously.

* Di Methyl Ether of d-Tubocurarine Iodide. Supplied through the courtesy of Eli Lilly Research Laboratories, Indianapolis.

CLINICAL RESULTS

Induction of Anesthesia. The induction of anesthesia was rapid and complete in all patients. The amount of drug required for induction averaged 310 mg. and ranged from 100 mg. to 625 mg.

The patient requiring 625 mg. of the drug for induction was a robust youth, 17 years of age. The premedication had been inadvertently omitted. Hiccoughing occurred in four patients during induction of anesthesia with the drug. This complication was easily eliminated by deepening the level of anesthesia. Mild laryngospasm occurred in two patients. Additional amounts of 03620 relieved the spasm. Only minimal reduction in tidal volume was observed in any of these patients during the induction of anesthesia. A few patients had a slight drop in systolic blood pressure varying from 10 to 20 mm. of mercury. No change was noted in the diastolic limb of the pressure.

Maintenance of Anesthesia. Anesthesia was easily maintained with 03620, N_2O, and O_2. The average amount of the drug required for maintenance of anesthesia was 385 mg. and ranged from 50 to 1200 mg.

Hiccoughing appeared in two patients during the maintenance of anesthesia. Deepening the level of anesthesia eliminated this complication immediately. Mild respiratory depression occurred in one patient. At no time was compression of the rebreathing bag necessary to keep the patient oxygenated. Laryngospasm was not noted during the maintenance period of anesthesia even though many of the patients were exhibiting pharyngeal reflexes and frequently moving one or more extremities. No serious blood pressure complications occurred during this period in any of these patients.

All patients exhibited active reflexes in the operating room at the termination of anesthesia. The majority of the patients were oriented and mentally clear when leaving the operating room. Eight patients retched, with or without nausea and emesis, while still in the operating room. This was not considered an unusual or serious complication.

POSTOPERATIVE PERIOD

Forty-three patients remained awake and in full possession of their reflexes after being returned to the ward. Seven patients remained drowsy and sleepy for one to two hours after the operation. However, they were easily aroused and would obey all commands.

One patient developed an attack of bronchial asthma which persisted for the first twenty-four hours postoperatively. This was easily controlled by the usual measures employed in the treatment of asthma. Although this patient had not revealed a history of previous asthmatic attacks in the preoperative history and physical, such was revealed in a postoperative interview.

Fifteen patients vomited once or twice during the first twenty-four hours postoperatively. This was not a serious complication. Many of these patients were receiving an opiate for the control of pain and it was felt that this was a contributing factor.

One patient showed evidence of agitation in the postoperative period. She was very cooperative to all suggestions made during this period. These symptoms completely disappeared in forty-five minutes.

DISCUSSION

Although the number of cases which form the basis of this preliminary report is small, several points concerning the anesthetic qualities of this new spirothiobarbiturate, 03620, may be mentioned. This anesthetic agent was applied satisfactorily to the range of patients ordinarily considered to be candidates for intravenous barbiturate anesthesia. The periods of induction and maintenance of anesthesia and the recovery period were relatively free of any serious complications directly attributable to the anesthetic agent. The incidence of retching, with or without nausea and emesis encountered at the termination of anesthesia and during the first few days postoperatively, was a source of some concern. At this time, however, it is not possible to associate this phenomenon directly with 03620. A more thorough clinical trial should clarify this point.

SUMMARY

The chemistry and pharmacology of a new spirothiobarbiturate, 03620, and the results obtained with this agent in fifty selected anesthesias have been presented. It is believed that further clinical trial of this agent is indicated.

ANESTHETIC MANAGEMENT OF CARDIAC PATIENT WITH REFERENCE TO DIAGNOSIS AND TREATMENT OF CARDIAC ARRHYTHMIAS*

VINCENT J. COLLINS, M.D.†

NEW YORK CITY

IN THE MANAGEMENT of any patient for anesthesia and surgery procedures should be instituted which interfere minimally with physiologic function. Techniques should be selected that will provide optimal working conditions, yet will not jeopardize the patient's life and will enable him to recover postoperatively. To achieve these all-inclusive aims, there are three major requirements:

1. Evaluation of physical status, cardiac condition, cardiac capacity and pulmonary sufficiency.
2. Surgical skill and experience.
3. Knowledge of the effect of various anesthetic agents and techniques on the heart, circulation and metabolism in general.

It can be inferred from the above requirements that there are three physicians involved in the management of a surgical patient. The first physician is the internist. It is his duty to evaluate the physical status and determine the degree of functional capacity of the patient. With him rests the final cardiac diagnosis, the determination of the extent of cardiac damage and the estimation of cardiac reserve; the state of pulmonary physiology and pulmonary sufficiency; and the metabolic state of the patient. These factors must be made known to the anesthesiologist and to the surgeon. It is our feeling in anesthesia that physical status is the province of the internist. On the other hand, the estimation of operative risk is actually the province of the anesthesiologist and the surgeon. A distinction is drawn here between operative risk and physical status. This idea is perhaps somewhat new and it therefore deserves explanation. Physical status is merely part of the operative risk. Operative risk not only considers physical status but considers the exact operative procedure, the ability of the surgeon, operative conditions, and the ability and skill of the anesthetist. It is readily seen that four of these factors are not always completely known to the internist. For example, there is a wide variation in the abilities and techniques of all surgeons. Some surgeons are what we call capillary surgeons. They endeavor to stop bleeding from every capillary that

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† Director Department of Anesthesiology, The St. Vincent's Hospital, New York City.

* Presented at the First Annual Heart Post Graduate Course by the Indiana University School of Medicine, Feb. 15, 1950.

is encountered. In so doing, they expend a great deal of time unnecessarily and they injure a great deal of tissue. Again, operative conditions depend so much on who the scrub nurse is, who and how many nurses are circulating and what the extent of their training is. A simple requirement such as the immediate availability of suction may sometimes mean the difference between failure and recovery.

The second person involved in the management of the patient is the surgeon. The surgeon's sphere is to evaluate the surgical condition, decide on what procedure will restore anatomical continuity and how this can best be accomplished, and finally he should present his requirements to the anesthesiologist. The prime requisites for a surgeon are gentleness in the handling of tissue and expedition of his procedure. We have in anesthesia an axiom regarding surgeons which states that a poor surgeon needs a good anesthetist and the good surgeon deserves one.

The anesthesiologist is the third person involved and his province is to make a composite picture of the internist's evaluation, of the surgeon's requirements and the patient's attitude. From these he should select a technique and an agent that will interfere minimally with physiology and enable the patient to go through the operation and return to his room in as favorable condition as possible. It is his prerogative to choose the anesthetic technique and the agent. In outlining this ideal concept of anesthetic management, I am assuming that the anesthetist is an anesthesiologist, and I use this term advisedly. The anesthesiologist is not a technician. He should act as the internist in the operating room. As such, he should:

1. Be a fairly good diagnostician, familiar with most common medical conditions, their prevention and treatment.
2. Be thoroughly cognizant of the surgical maneuvers.
3. Be a good pharmacologist.
4. Be a good physiologist.
5. Be a good technician.

In fulfilling these duties the anesthetist, as a physician, has had to apply whatever basic knowledge he has acquired to problems in the operating room, and has attempted classification of these problems as well as treatment. This has been done under specific handicaps. The problems are all acute and in the nature of emergencies. Symptoms are not available and the anesthetist has had to rely on physical signs alone. Of aids employed to arrive at a correct diagnosis the following are in current use:

1. Vital sign determinations: changes in pressure, pulse, respiration, capillary circulation.
2. Continuous kymography of arterial pressure and pulse.[1]
3. Oxyhemoglobinograph readings.[2]
4. Blood volume determination.[3]
5. Cardiac output by catheterization.[4]
6. Direct writing electrocardiography.

Before entering into a discussion of electrocardiography in the operating room and of arrhythmias occurring during anesthesia, it is worth-while that we summarize some of the anesthetic principles as related to the cardiac patient.[5]

Preoperative Preparation: A little psychotherapy finds a wide field of usefulness in cardiac patients. Explanation, stress of the lack of harmful effects of the contemplated procedures and reassurance are the tools. They can be used by all personnel concerned and are used by the anesthesiologist on his preoperative visit.

Sedation should be adequate. Short-acting barbiturates in judicious doses are indicated for sleep and for preanesthetic medication. It should be emphasized, however, that all sedative drugs should be definitely minimized in the older patient. If any hypoxia is expected to develop from the use of a drug, then this drug should not be employed. Demerol has been employed extensively and successfully in premedication of our cardiac patients. In the geriatric patient we use homeopathic doses. Demerol, besides being a sedative and analgesic with minimal respiratory depressant effects, also exerts a protective action against the arrhythmias during cyclopropane anesthesia.[6] It has also been experimentally demonstrated that it protects against the cyclopropane arrhythmias induced by epinephrine.

It is known, too, that an adequate preoperative diet with high vitamin intake is of tremendous importance in improving cardiac physiology. For example, thiamine is concerned in the oxidation of pyruvic acid, and in its absence tachycardia and cardiac dilatation may occur. An adequate quantity of these substances is, therefore, of benefit to a heart whose cellular respiratory mechanisms will be under stress.

Avoidance of hypoxia: Brief consideration of a universally accepted principle, namely the avoidance of hypoxia is warranted. The heart muscle has no oxygen reserve; it is as vulnerable as is the brain to diminished oxygen supply. In the seriously ill cardiac patient it is therefore important to begin oxygen administration almost immediately on arrival in the hospital; it is hardly necessary to remind the good anesthetist that oxygen and adequate oxygen tension be provided during anesthesia. This allows of no modification, and the anesthetist who employs concentrations of oxygen less than 20 percent as is often done with nitrous oxide is jeopardizing the patient's life.

Choice of Anesthesia: One should fit the anesthetic agent and the technique to the patient and to the needs of surgery. All agents and techniques have at one time or another been condemned for the cardiac patient. Actually, no generalization

should be made regarding this or that agent as being either good or bad. Each drug and each technique has its place and usefulness in the anesthesiologist's armamentarium.

Technical Considerations: A good airway is a prerequisite to any good inhalation or general anesthesia. It should not only be clear and patent, but also adequate. A restricted airway impedes gaseous exchange. A well-known axiom is that noisy respiration is obstructed respiration. In elderly, edentulous patients, where there is relaxation of the pharynx, an endotracheal airway is indicated. An endotracheal airway is also indicated in situations where an abnormal posture is to be assumed or the chest to be opened.

Compensated or aided respiration is valuable. The technique consists in the assisting of inspiration by graded manual pressure on the breathing bag. By this means a patient's effort is diminished and fatigue lessened.

Positions interfering either with respiration or circulation are to be condemned. The head-down position is deleterious to the circulation in most cardiac patients. The causes of dyspnea do not disappear during anesthesia—only the patient's complaint disappears. Yet, orthopneic patients are often seen in steep head-down position or in Trendelenburg position, indicating both a lack of common sense and physiologic comprehension of the situation on the part of the operator.

Another situation seen on the operating table which the anesthetist must guard against is that of the "tired assistant," who rests on the patient's chest or accumulates instruments on the chest. This is intolerable.

Fluctuations in blood pressure and procedures which cause these fluctuations must be avoided. Changes in diastolic pressure must be combatted since the coronary arteries fill during diastole. The use of vasopressor drugs should be minimized, but they are definitely indicated for the stabilization of blood pressure, in which case neosynephrine is the agent of choice.

Fluid therapy is a controversial issue, particularly in the cardiac patient, but the safest rule is to replace whatever is lost. During surgery it is obvious that blood is going to be lost; therefore the vascular fluid compartment should be maintained by giving blood. One should not temporize because the patient has a cardiac problem. Blood should be started early and administered slowly. This is a far better arrangement than suddenly to find one's self in the situation where a large volume is needed in a short period, as when circulation is rapidly deteriorating from hemorrhage. Altschule has shown that quite large amounts of fluid can be given over a period of several hours without causing any cardiac or circulatory disturbance. In the person without cardiac disease, saline or glucose administered at rates of 20 cc. or less per minute results in no significant changes in cardiovascular function. At greater speeds prolonged rise in venous pressure and other changes may occur. The administration of fluids at 10 cc. per minute or less to cardiac patients results in little change in cardiovascular function.

This discussion of anesthetic principles related to the cardiac patient in general is contingent on a discussion of cardiac arrhythmias occurring during anesthesia and surgery. Since so much of body physiology depends on cardiac function, and since a growing need for adequate information covering the cardiac mechanism during anesthesia is apparent, the use of continuous direct-writing electrocardiography has been employed. It is my belief that this will be standard procedure in every surgical theater within the very near future.

In using electrocardiography in the operating room, the first significant question to be answered is what constitutes a serious abnormality of cardiac function during anesthesia.[7] We should be aware of the fact that with the exception of ethylene the other common inhalation agents, as well as our regional anesthetic agents, are capable of precipitating cardiac irregularities. Ether produces changes in heart rhythm, especially of auricular origin. The types favored are concerned with impaired conduction and downward displacement of the pacemaker, namely, sinus tachycardia, slowed AV conduction, AV nodal rhythm, partial block and occasional ventricular extrasystoles. Changes in rhythm due to the abnormal formation of impulses are relatively rare. Marvin[8] found by electrocardiographic study either delays in AV conduction with irregular nodal rhythms or partial blocks in 50 percent of patients under ether anesthesia. Maher[9] found nodal rhythms in man in 32 out of 70 cases studied and also frequent disappearance of the P wave with QRS changes in about 20 percent of the patients. Kurtz[10] reported a displaced pacemaker in 65 percent of a series of electrocardiograms taken on etherized patients and extrasystoles in 20 percent. Most of the abnormalities of rhythm occurred during ascent of anesthesia or during induction and were readily reversible.

Cyclopropane has two outstanding cardiac effects, namely, bradycardia and abnormal rhythm of ventricular heterotopic origin. Taylor[11] reported an incidence of 6.5 percent of arrhythmias in a large series of cases anesthetized with cyclopropane. These arrhythmias were determined entirely by clinical means. However, by the use of electrocardiography Kurtz demonstrated that 48 percent of a series of cases anesthetized with cyclopropane had a change in pacemaker, and 58 percent developed extrasystoles of ventricular origin. Most observers report that in man cyclopropane causes a slowing of the heart rate below that of the normal level, and that this slowing is probably a simple vagal effect.

The mechanism of the more serious irregularities

occurring with cyclopropane has been investigated by Meek and his co-workers.[12, 13] It has been determined that cyclopropane reflexly sensitizes the heart to the development of irregularities and that these irregularities may be precipitated by either exogenous or endogenous epinephrine.[14] For the reflex to be effective, the sympathetic nervous system and the hypothalmus are necessary, and it has been recently observed that the site of stimulation is in receptors in the peripheral 6 cm. of the abdominal mesentery.[15]

SIGNIFICANT CARDIAC ABNORMALITIES BY ELECTROCARDIOGRAPHY

I. **Disturbances in Initiaton of Impulses**

A. Ectopic sinus or auricular tachycardia. Paroxysmal auricular or nodal; auricular fibrillation: mechylolvagus stimulation—digitalis—quinidine.

B. Sinus or AV nodal bradycardia of extreme degree: Atropine. With failure to revert to and remain normal after atropine, a preterminal state probably exists.

II. **Disturbances in Conductivity**

Evidence of anoxemia; drug effect—chloroform, ether.

A. ST segment and T wave abnormalities.

B. Major disturbance of intraventricular conduction (bundle branch block).

C. Complete AV dissociation (exclusive of interference dissociation).

D. Sinus arrest.

III. **Disturbances in Myocardial Excitability (Contractility)**

Myocarditis; Anoxemia; hyperpotassemia; drug effect—cyclopropane, deep ether. Ectopic arrhythmias with potential danger of ventricular fibrillation.

A. Ventricular premature systoles: Procaine; Quinidine.

B. Ventricular tachycardia: Quinidine.

IV. **Cardiac Arrest**

A. Preterminal:

1. Marked bradycardia.
2. ST segment deviation.
3. Ventricular extrasystoles.

B. Terminal:

1. Mechanical asystole or standstill; Manual Massage (?) epinephrine; amines.
2. Cardiac ventricular fibrillation: Procaine topically and intravenously; quinidine intravenously; electric shock.
3. AV Dissociation with absence of ventricular response; Manual massage and intravenous procaine.

In the treatment of various cardiac arrhythmias that occur during anesthesia and surgery and related to the state of excitability produced by the anesthetic, either directly or indirectly, several techniques and drugs have been introduced and employed. Francois-Franke[16] in 1892 used cocaine derivatives to control disorders of rhythm. Topical application of one percent procaine or metycaine has been employed by Beck[17] during cardiac surgery in man. The original technique was to allow the procaine solution to drip continuously on the epicardial surface. The effectiveness of pericardial application on the underlying myocardium has been experimentally demonstrated by Mautz.[18] The procaine apparently acts as a local sedative. This technique is somewhat cumbersome and will often result in a flabby myocardium and is not always effective. A modification has been the instillation of 10 cc. of one percent procaine into the pericardial sac when an arrhythmia actually occurs. However, the topical technique has been supplemented by the intravenous injection of two percent procaine as recommended by Burstein.[19] The dose employed is from 50 to 150 mg. or more in divided doses until the abnormal rhythm disappears. The results are often dramatic.

The use of bilateral vagal nerve blocks[20] in the neck for the prevention of cardiocirculatory depression from the surgery with its attendant changes in rhythm has been advocated and employed with good results, particularly during pulmonary hilar dissection.

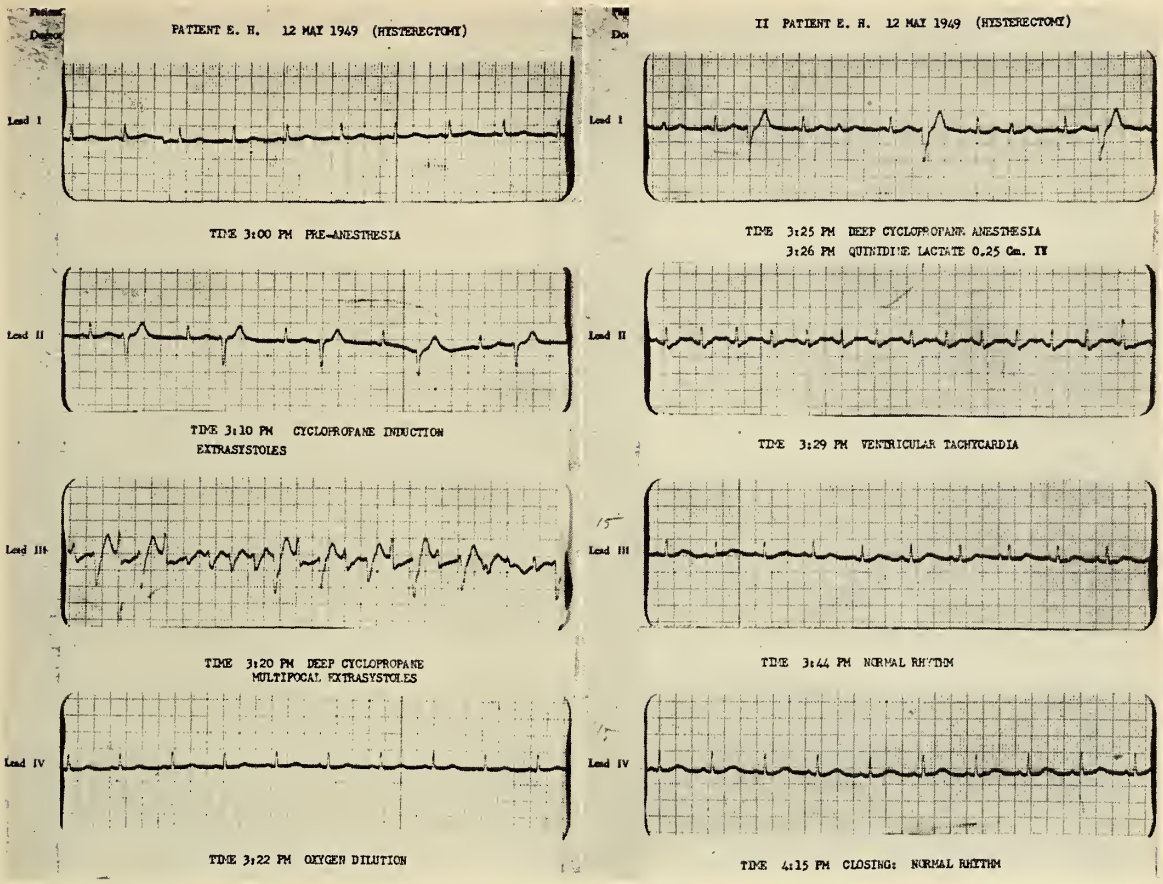
Electric countershock has been employed to control ventricular fibrillation by both Beck[21] and Fanteux.[22]

In cardiac arrest it is imperative to differentiate between mechanical asystole or standstill and ventricular fibrillation.[23] It is because of failure to do this that epinephrine has been attended with fatalities and condemned. In one series ventricular fibrillation occurred in only 26 percent of terminal cases.[24] It is probably of definite value in arrest from mechanical asystole but is absolutely contraindicated in cases of arrest due to fibrillation, where its use may perpetuate the fibrillation[25] and produce a certain fatality.

In these cases of arrest there must be artificial maintenance of circulation by manual massage of the heart.[25, 27] To accomplish this there must be adequate exposure of the heart. The direct approach is the only adequate one: a tranverse incision in the fourth left interspace with division of the fourth and fifth costal cartilages is made by the surgeon. The heart is grasped and massaged by the rhythmical application of an external force to the ventricles beginning at the apex and passing to the base; a typical "milking action" to stimulate normal dynamics. This is performed 20 to 40 times per minute depending on the "adequacy with which the ventricles fill between compressions." There is disagreement with this.

Secondly, artificial maintenance of respiration by rhythmical intermittent inflation of lungs must be carried out with oxygen.[27] Thirdly, posture

Figure 1



should be adjusted so that the legs are elevated about 5° and the head and chest are slightly down. This is conducive to maximal gravitational benefits in achieving an adequate venous return without causing undue cerebral congestion.[28] Fourth, specific drug therapy should be considered. For asystole intravenous epinephrine[29] or an intracardiac injection may be given. In the latter instance it is preferably given in to the right auricle.[30] For fibrillation, quinidine intravenously or procaine intravenously and electric shock according to the technic of serial defibrillation are indicated,[31] while epinephrine is anathema.

Of the drugs used in the control of arrhythmias other than standstill, intravenous procaine has been the most efficacious agent. Although Wiggers[32] found experimentally that procaine administered to dogs raised the resistance of the ventricles to fibrillation, he found no instance in which the heart became entirely refractory. Fauteux[22] also found that procaine did not always prevent fibrillation. Many anesthesiologists have experienced failure with the use of procaine intravenously to restore regular cardiac function. Because of these failures, and to support our contention that quinidine is the drug of choice in ventricular fibrillation, investigations have been carried out with a drug that historically is concerned with controlling irregularities of cardiac rhythm. The drug which we have employed is an intravenous preparation of quinidine, namely quinidine lactate, and there have been three phases to our investigations:

In the first phase evidence was obtained showing that the intravenous administration of quinidine lactate clinically was effective in controlling arrhythmias during cyclopropane anesthesia.

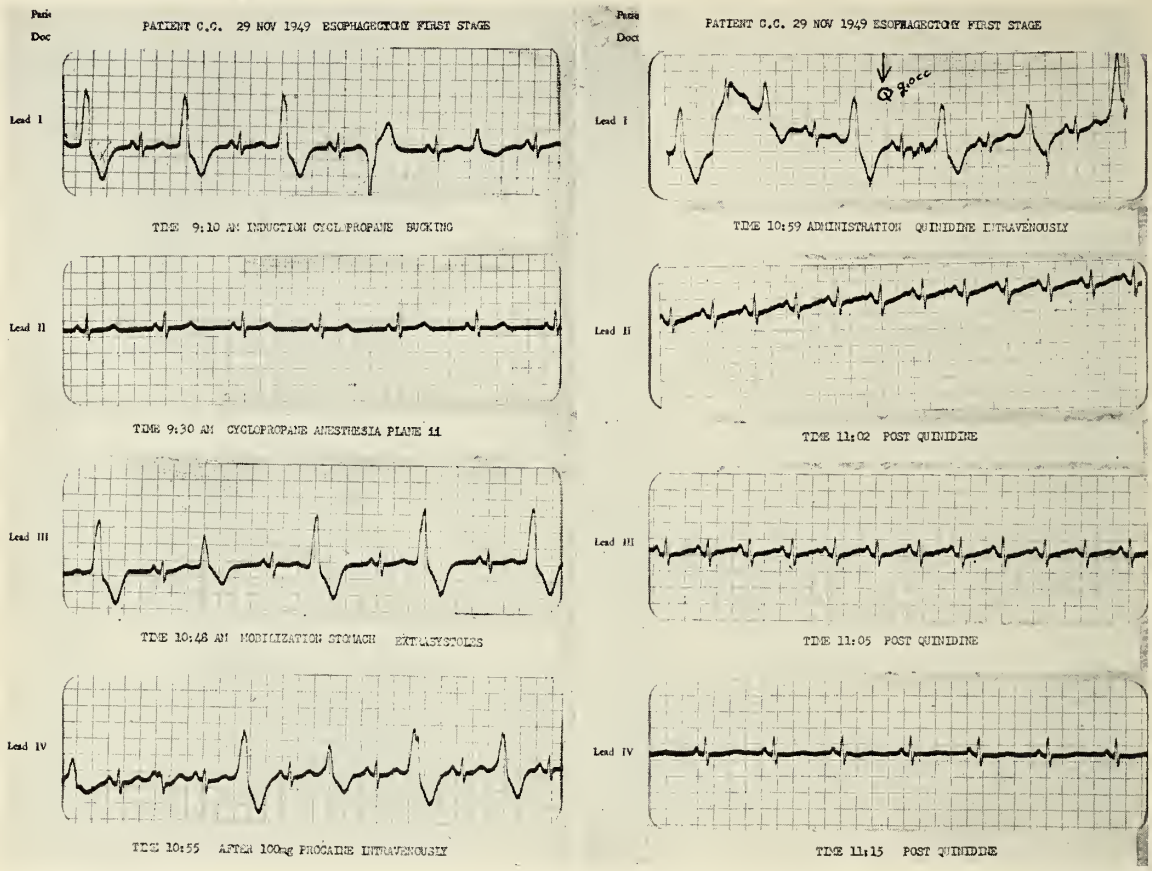
In the second phase we have endeavored to learn the minimal effective dose in stopping abnormalities of rhythm.

In the third phase we have been administering quinidine lactate as part of our preanesthetic medication and have determined its effectiveness in preventing the development of cardiac arrhythmias during cyclopropane anesthesia. In this latter phase we have also obtained information indicating a specific period of protection following the administration of the drug.

An analysis of 38 cases of cardiac arrhythmia occurring under cyclopropane anesthesia revealed the following disorders: auricular and ventricular tachycardia; extrasystoles; coupling; auricular fibrillation, and electrocardiographic tracings which our cardiologist termed complete dysrhythmia.

In the first 25 cases,[33] as soon as a disorder of rhythm was detected, either clinically or by electrocardiography, an intravenous injection of from 0.2 to 0.4 gm. of quinidine was made. In all cases the quinidine was beneficial. Improvement in rhythm

Figure 2



was clinically evident within 5 minutes, with complete restoration to regularity within 11 minutes.

In the next 10 cases smaller doses between 0.1 and 0.2 gm. were employed and found to be as effective as the larger doses.

In three cases a single prophylactic and preanesthetic injection was made and in one instance no arrhythmias developed during the four and one-half hours of surgery, while in two instances arrhythmias developed after four hours and the quinidine had to be repeated.

To illustrate these experiences four case reports are here summarized:

CASE 1

J. T., a thirty-seven-year-old woman with a diagnosis of active pulmonary tuberculosis, submitted to right pneumonectomy. Preanesthetic medication consisted of oral seconal, 0.1 gm. two hours preoperatively, and subcutaneous demerol, 75 mg. with 0.4 mg. of scopolamine seventy-five minutes preoperatively. Induction with cyclopropane was smooth and rapid. Further anesthesia then consisted of an ether-cyclopropane mixture. Intubation was attempted under direct vision with McIntosh laryngoscope, but exposure was poor and hence a number 35 French Magill catheter was introduced by blind nasotracheal technic. Pharynx was packed, and a closed to-and-fro carbon dioxide absorption system was set up, with the patient in the left lateral position. Surgery began twenty minutes after start of anesthesia. Respirations were compensated throughout most of the procedure. One hour after surgery began, a dysrhythmia was detected and a fall in blood pressure noted. Procaine, 90 mg., was given intravenously and a second dose of 100 mg. injected five minutes later. Pulse rate was between 120 and 180 and rhythm completely irregular. Observation of the heart at this time showed the auricles to be fibrillating and the ventricles to be responding irregularly. Surgery was suspended. Because nine minutes had elapsed since the first injection of procaine without improvement, 0.3 gm. of quinidine lactate was given intravenously and 0.1 gm. intramuscularly. Rhythm improved and was completely regular in six minutes although rate was rapid. At the end of eleven minutes tachycardia disappeared, and rhythm was completely regular, although cyclopropane was continued as needed.

CASE 2

E. H., a twenty-nine-year-old woman, arrived in the operating room for myomectomy. She received morphine sulphate 10 mg. and scopolamine 0.4 mg. subcutaneously one and a half hours before anesthesia. Induction and maintenance of anesthesia were with cyclopropane and oxygen, and a closed to-and-fro carbon dioxide absorption system was employed. A tachycardia developed about fifteen minutes after the start of anesthesia, while the surgeon was doing a preliminary dilatation and curettage. Electrocardiographic equipment was arranged and tracings made (Fig. 1). The anesthesia was lightened so that the pharyngeal airway had to be removed, and tachycardia disappeared; occasional extrasystoles remained. As soon as anesthesia was deepened to second plane of stage III anesthesia, a tachycardia developed which was replaced by a continuous run of ventricular

extrasystoles. At this point 0.25 gm. of quinidine lactate was administered intravenously. Tracings were made every thirty seconds thereafter. At the end of three minutes only occasional extrasystoles were present, and a completely regular rhythm supervened in four and a half minutes at the rate of 100 beats per minute. At the end of five minutes the rate was 72 beats per minute. No abnormalities of rhythm were further noted, even though deep cyclopropane anesthesia, accompanied by controlled respiration, was used for peritoneal closure.

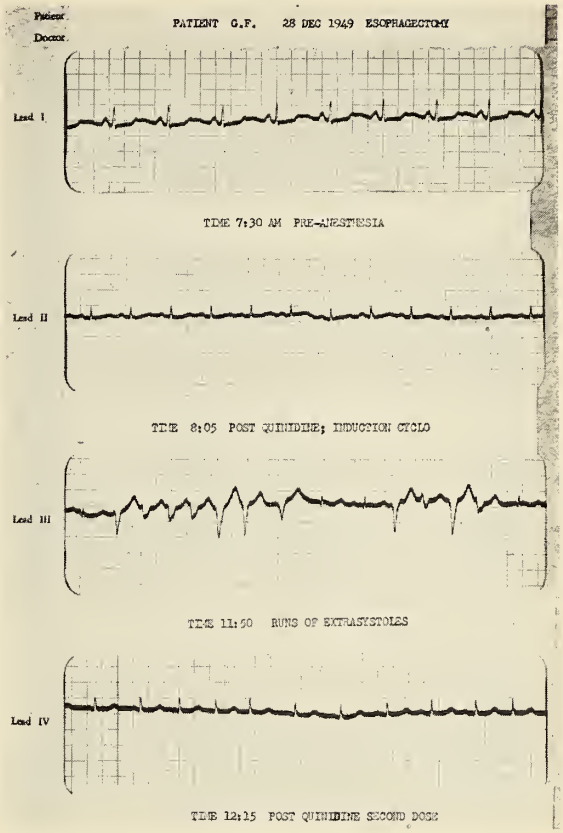
CASE 3

C. C., a fifty-three-year-old white male, with carcinoma of the esophagus, came to the operating room for second stage esophagectomy. Blood pressure was 124/84, pulse 84 and regular, and respirations 20. Induction and maintenance of anesthesia was with cyclopropane and oxygen with ether topping. Two hours and 45 minutes after induction, during a manipulation of the stomach, the patient exhibited ventricular extrasystoles on the continuous recording EKG (Fig. 2). One hundred milligrams of procaine was given intravenously without any significant change in the EKG patterns. Two and one-half minutes later 2 cc. of quinidine lactate was given intravenously. Within another two and one-half minutes the arrythmia had reverted to a normal sinus rhythm and remained so during the next 90 minutes of surgery. Surgery was completed under cyclopropane and oxygen anesthesia with ether topping.

CASE 4

G. F., a fifty-nine-year-old white male, was submitted to second stage esophagectomy for carcinoma of the esophagus. Blood pressure at the start of anesthesia was 154/84, pulse was 120, and respirations were 20. Quinidine lactate 0.15 gm. was given intravenously as a prophylactic dose at the start of anesthesia. On entering the left chest the surgeon procainized the left vagus. After four hours of anesthesia, which was induced and maintained with cyclopropane and oxygen under controled or compensated respiration, a run of ventricular extrasystoles was recorded on the EKG (Fig. 3). Almost immediately the anesthetist gave 1 cc. of quinidine lactate i.v. Within one and one-half minutes the rhythm was again normal. For the next four and one-half hours of surgery the rhythm remained normal. Up to this time 5000 cc. of blood had been given. After seven and one-half hours of surgery, cardiac arrest suddenly occurred and the heart was found to be in asystole on inspection. Cardiac resuscitation was undertaken within 90 seconds and epinephrine given into the myocardium and intravenously with a restoration of spontaneous, effective cardiac rhythm in 24 minutes. The patient was given one-half a digitalizing dose of cedilanid i.v. with a further increase in systolic force of concentration. However, after another one-half hour the heart went into asystole again, and all further efforts at resuscitation failed. Autopsy revealed no gross or microscopic pathology of the heart.

Figure 3



SUMMARY

We are still in the process of investigating the effectiveness of quinidine lactate. However, we can make some definite statements at the present time.

1. Arrhythmias occurring during cyclopropane anesthesia have been successfully treated by quinidine lactate administered intravenously.
2. The arrhythmias from the examination of the electrocardiographic tracings are reverted to normal in four to six minutes; the paradoxic tachycardia which usually follows the slowing of an auricular fibrillation disappears in the subsequent four minutes.
3. A minimal dose of quinidine lactate in the neighborhood of .1 to .2 of a gram has been found to be effective.
4. From a single preanesthetic minimal dose we have determined that protection is afforded for approximately two to four hours. At this time it now appears that a second quinidine dose should be administered.
5. No untoward cardiovascular reactions have been noted at the time or subsequent to the administration of the quinidine and in fact there has been improvement in the general condition of the patient with an elevation of the systolic blood pressure. Neither has respiratory depression nor bronchospasm been seen in the cases treated. No idiosyncrasy has been detected in a careful postoperative follow-up.

CONCLUSION

Some concepts in anesthesia have been presented, and anesthesia principles in the management of the cardiac patient have been outlined. Electrocardiography of the continuous direct-writing type is presented as a newer operating room tool. By

this means various cardiac abnormalities have been determined and a suggested classification presented.

In the treatment of cardiac arrhythmias occurring during anesthesia and surgery, it is believed that intravenous procaine is effective in treating or preventing arrhythmias of supraventricular origin. This drug is also the one of choice when ether is the sole anesthetic agent. With respect to cyclopropane arrhythmias, quinidine lactate has been found particularly effective in preventing and treating arrhythmias of ventricular origin.

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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Editor Emeritus: E. M. Shanklin, M.D., Hammond, Indiana

Editor: Frank B. Ramsey, M.D., 201 Hume Mansur Building, Indianapolis 4, Indiana.
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CIVIL DEFENSE AGAINST ATOMIC ATTACK

EXPERT testimony recently made before the Joint Congressional Committee on Atomic Energy presents an excellent summary of the extent and detail of planning which has already been accomplished for the organization of civil defense against atomic attack.*

Medical and health services comprise one of the most important aspects of the problem. Study of the Japanese bombings has shown that, except for its enormous magnitude, the medical care of atomic bomb casualties is not difficult. It consists chiefly of the care of blast injuries and burns, and to a minor extent includes the treatment of radiation casualties.

However, in the event of a successful atomic attack upon one of our cities, the number of injured will be unprecedented; and we may assume that medical care for such a disaster must be accomplished with inadequate numbers of all types of health personnel, handicapped by severe shortages of supplies and hospital facilities.

While research work is currently being done to improve the therapy for radiation sickness and all other types of injury likely to be inflicted by atomic warfare, it is evident that the basic problem is not now one of outlining effective treatment for individual cases.

The real problem which confronts those in charge of medical planning is to devise means by which an enormous number of casualties may be cared for by the comparatively meager resources which will be available.

Careful inquiry into the possibility of a standardized treatment for cutaneous burns may develop a system of treatment which will enable the accumulation of uniform supplies and the training of auxiliary personnel in the conduct of treatment. Medical officers have found that it is possible to train laymen in a relatively short time, so that they may successfully carry out adequate first-aid therapy with a minimum of professional supervision.

The burns and radiation sickness which result from atomic explosions require large amounts of blood for transfusion. This is a therapeutic agent which cannot be acquired and stored over a long period of time. According to our present knowledge it must be used within a 30-day period. Research may make it possible to extend this storage period,

* Physicians are invited to direct inquiries on the subject of Civil Defense Against Atomic Attack to Dr. Norvin C. Kiefer, Director Health Resources Division, National Security Resources Board, Washington, D. C.

but for the present our plans must include the training of technicians and the maintenance of supplies sufficient to obtain and process fresh blood in the amount of several million pints, after the need for it has developed.

Medical and other disaster relief services must be based on a centripetal plan; all aid should be planned to converge on the stricken community from locations outside the damaged area. An atomic explosion will produce so many casualties among the local medical personnel, and will damage hospitals and destroy locally stored medical supplies to such an extent that only distant sources can be relied upon.

Disaster relief teams for any given community must be organized entirely from surrounding towns and cities. Buildings for use as temporary hospitals must be selected many miles away from possible target areas. Medical supplies must be stored in sparsely populated spots where they will not be easily destroyed.

While the United States strives for and bends every effort toward the maintenance of world-wide peace, it is only prudent to make reasonable plans for our defense, in case that cause fails. One of the important phases of the wartime disaster relief planning is the establishment of training courses in the treatment of radiological injuries. The Atomic Energy Commission is now offering courses to a limited number of physicians from each state, who it is expected will form a nucleus for the training of all physicians in this important work.

NATIONAL "HEALTH" INSURANCE*

NATIONAL health insurance is the term applied by its advocates to certain legislation now pending in Congress. This legislation, however, does not deal primarily with the maintenance of the public health, or with the prevention of disease on a national scale; it concerns the prepayment of medical care.

How much does adequate medical care have to do with the maintenance of the public health?

When the services of a doctor are required, it is because the maintenance of the public health, so far as the person calling for these services is concerned, has broken down. His wife's attack of appendicitis, his child's infantile paralysis, his own coronary occlusion or his father's cancer of the stomach might have been avoided, or they may at some future time (if the cancer campaign, the heart campaign, the poliomyelitis campaign and others pay off) be preventable; nevertheless, whenever one of these crises does occur, it is time to call not the Public Health Service but the physician or surgeon.

Although practicing physicians all try to include in their care of the public the newest preventive procedures offered by the investigative branch of the profession, and although they talk a great deal about preventive medicine, the fact remains that the great bulk of their work is to visit the sick, care for the suffering and comfort the dying. No one will deny that they bring relief and comfort, or that often enough they are even able to restore health. But to insure health they are unable.

As citizens, physicians still have no acute problem in the cost of medical care. They usually pay no doctor's bills, thanks to professional courtesy, and even hospitals are inclined to deal kindly with them when they need hospital services. But are they and their families thereby healthier than others? Do they have fewer bellyaches or ruptured intervertebral disks and less coronary disease, or are they better protected against poliomyelitis or pernicious anemia than their lay brethren? They should be, if there were anything to this cry that cheaper and more available medical care brings better national health. But the actual answer is *no.*

Sensible progress in attaining better national health was made when yellow fever and malaria all but disappeared with the mosquitoes that bore them and when typhoid fever was practically eradicated by adequate sewage disposal, and it will be made in the future when the ill understood conditions that make rheumatic fever a disease of the poorly fed and poorly housed, or coronary-artery disease an affliction of the well fed and well housed, are studied, attacked and modified.

Doctors no less than others are willing to pay fair taxes to bring about better health. But it seems to them that to spend money in sums so vast that they threaten the national economy on mere stopgap methods such as providing cheaper medical care is neither necessary nor wise. It is fine to be able to supply hospital beds, intravenous feedings, x-ray examinations and craniotomies for the victims of automobile accidents, but it would be even finer to be able to prevent a substantial number of the accidents. It is by means of preventive medicine—not by free medical care—that efforts to attain better national health are most apt to succeed.

* Reprinted from *The New England Journal of Medicine* of April 13, 1950.

CATASTROPHE COVERAGE

THE medical profession and all those who are interested in various forms of voluntary sickness insurance will watch with interest the development of plans to protect patients against the cost of long-term illnesses.

One of the shortcomings of medical and surgical insurance, as it is usually sold, is that it does not cover the expenses of the illnesses which are catastrophic because of their long duration. Chronic diseases are not only costly to treat over an extended period of time, but also, if they involve the breadwinner of the family, they impose a serious loss of income.

The basic aim of medical insurance is to spread the cost of expensive and relatively infrequent illnesses among a large number of people, most of whom will never be affected. It is of little use to insure against the expense of minor and common diseases, since most individuals can budget for ordinary illness out of income.

It is thus evident that the more infrequent and the more costly an illness is, the more ideal it is for coverage by insurance. The main reason that long-term sickness is not covered more often is one of actuarial experience—or rather the lack of it. No one has been able to predict with reasonable certainty the incidence and magnitude of the chronic diseases. As a result, it has not been possible to include such risks in the voluntary plans during their early development.

Blue Shield plans were set up originally to cover illness over a comparatively short and limited period of time. It is characteristic of such plans that they have been able to develop and increase their memberships at a phenomenal rate and remain in sound financial status. As their reserves have increased and as actuarial experience has been gained these plans have extended their coverage and have liberalized their contracts.

One of the most progressive extensions of insurance was made recently by California Physicians' Service, the Blue Shield plan of that state. By paying a small sum in addition to the regular monthly dues, group contract holders may have coverage for medical and surgical care for a list of 23 diseases or conditions for a period of a full two years or to a maximum expenditure of $5,000, whichever is reached first. The diseases covered are cancer, poliomyelitis, rheumatic fever, diabetes, osteomyelitis, tuberculosis and others in the chronic disease classification.

Time alone will tell whether the additional premium will be sufficient to balance the outlay which this program will entail. The directors of the California plan think that it will, or that at least only minor adjustments will be necessary after experience has indicated the exact cost.

This is the kind of pioneering that is making the voluntary medical insurance plans great. One of the advantages of the voluntary system is that it must pay its own way. It cannot make up its shortages from general tax funds as is done in socialist England, and as has been proposed for this country under the compulsory plan. The voluntary plans must be conducted in a business-like manner, with a high return on the premium dollar to the patient, and with a low administrative cost. Innovations and extensions must be made only after careful study and limited trials, and then adopted only if they are financially sound.

Everyone interested in voluntary sickness insurance will watch with interest the development of the California plan for protection of patients with long-term illnesses.

Editorial Notes

DR. BURTON MYERS HONORED

The first annual Burton Dorr Myers Lecture, sponsored by Nu Sigma Nu medical fraternity, was presented at Indiana University School of Medicine on March 24 by Dr. H. Russell Meyers, professor of surgery, and chairman of the Department of Neurosurgery, State University of Iowa. Doctor Meyers discussed "Surgical Experiments in the Therapy of Certain Extrapyramidal Tract Diseases."

THUMB SUCKING

After making a rather extensive survey of medical, dental and consumer literature, as well as textbooks on the subject of thumb sucking, Paul J. Mandabach of Chicago has published a monograph on sucking habits. This monograph urges cooperation of physician, dentist, psychiatrist, psychoanalyst, physiologist, registered nurse, and hygienist in the interest of the child and his future life and in the interests of the parents with a view to treating the individual child with the habit, rather than a habit in a child. Copies of this monograph may be obtained without charge by addressing Paul J. Mandabach, Sr., 677 North Michigan Avenue, Chicago 11, Illinois.

NARCOTIC LICENSE

Physicians currently registered under the Federal Narcotic Law must file with the Collector of Internal Revenue in whose district they practice Form 678 (application for re-registration), together with an inventory of the narcotic drugs on hand, Form 713, and pay the tax of $1 on or before July 1, 1950. A copy of the Form 713 must be kept for a period of two years.

The Bureau of Narcotics has issued a warning that official government forms, prescription pads and supplies of narcotic drugs should be securely safeguarded against theft.

President's Page

OUR BETTER HALVES

JUNE is bustin' out all over, and so is the Woman's Auxiliary to the Indiana State Medical Association. We doctors have always looked upon the women of the Auxiliary with particular pride because, bless their hearts, they're our wives. But now we're obliged to look upon them with increasing admiration and in great amazement, for they have proved that they are not a group content to bask in reflected glory—not at all. Their unceasing efforts to thwart the advance of welfare statism, that creeping paralysis we're all fighting, has made them a power in their own right.

Dr. Ernest B. Howard of Chicago, assistant secretary of the A.M.A., spoke at the Sixth Annual Conference in Elkhart and recognized the outstanding achievements of "our better halves" when he commended them for their fine work. Their membership has risen from 900 to 2,200 in just one year—a startling 244 percent increase. They have seen that all doctors and their families were registered and qualified to vote in the primary election. And they have triumphantly carried the burden of the resolutions program. Their 1,200 resolutions against socialized medicine came from organizations which, altogether, not only represent one-half the population of Indiana but also account for 20 percent of all such resolutions in the entire country.

The directing power behind the Auxiliary's program has been Mrs. Truman E. Caylor of Bluffton, immediate past president. Her drive and devotion, together with the loyal support of her staff and all Auxiliary members, have made these remarkable results possible. In June Julia Caylor will give the official response at the A.M.A. convention in San Francisco. That she has been chosen to do this is a signal honor for the Indiana Auxiliary.

Since April 28 the presidency of the Auxiliary has been in the capable hands of Mrs. D. E. Lybrook of Galveston. We know that, under her guidance, our faithful cheering section will have another record-breaking year.

E. S. Black,

Medical Panorama by the Associate Editor

Another Medical Paradox

We live in the midst of alarms, with "drives" to raise money to fight cancer, diabetes, heart disease, poliomyelitis, arthritis, and others—all good and worthy causes. The various organizations back of the "drives" contribute much money to aid research in these fields. Although there has appeared a certain lack of coordination in these efforts, and some disproportion in emphasis, on the whole much progress has been made and many sufferers benefited. Yet there is another aspect of the central problem to which these activities are as facets to a diamond, and that is the necessity of educating those who will carry on the research and perform the clinical services envisioned by the good citizens who back the "drives."

The Dean of Yale School of Medicine, Dr. C. N. H. Long, has the following to say, in the *Connecticut State Medical Journal*, April, 1950:

> At the present time there is certainly no lack of young men and women in this country who wish to follow the profession of medicine. Last year some twenty-six thousand individuals throughout this country made application to the medical schools who were able to accommodate somewhat less than six thousand. Every college has a very large and increasing number of individuals taking the so-called pre-medical course. In the Yale School of Medicine last year we received fifteen hundred applications for the sixty-five places we have available at the present time.
>
> I am not saying for one moment that all these fifteen hundred or all these twenty-six thousand individuals were qualified for the profession of medicine, but certainly many more were qualified than it was possible to accept. The material is here to increase the number of doctors in this country.
>
> * * *
>
> There is a paradoxical situation in many medical schools today. I can, perhaps, use this school as an example of it. There has been unparalleled expansion in the amount of money available for research in the medical sciences. There has never been a time when so much money was available for medical research. Last year we received from various agencies of government and private foundations over $1,000,000. Now, research is carried out by trained men and women and the training of men and women for research in the medical sciences is carried out by the universities and the medical schools. Yet, in the midst of this plenty so far as research funds are concerned, this medical school operated last year at a deficit of over $600,000. It is the provision of adequate funds for medical education which is one of our crying needs at the present time. It must be apparent to you that unless medical education as well as research is supported not only will the provision of an adequate number of physicians for the needs of this country be impossible, but the progress of medical research which is carried out by the products of the medical schools and universities will be certain to be retarded.

Perhaps the paradox can be resolved by calling attention to it. Surely the business men who spark the "drives" can see the logic of maintaining the machinery of production so that it can cope with the demands made upon it to handle more material. Why not assign a percentage of the funds for research to the medical schools behind the research? Why couldn't you, gentle reader, take the matter up with those in your community who are active in such work? A word to the wise is often sufficient.

Fee-Gougers

There has been a great deal of favorable comment in various medical journals *re* the establishment of grievance committees for proper liaison with the public, et cetera. The following editorial appeared in *Drug Trade News*, for March 20, 1950, and shows that our druggist friends are interested, too:

> The action of the trustees of the American Medical Association, calling on state medical societies to crack down upon those physicians who make excessive charges for their services, strikes us as a good omen. It will be accepted as good faith upon the part of organized medicine of its desire and intention to remove or mitigate conditions within the profession which intensify the emotions underlying the Truman-Ewing plan for the socialization of medicine.
>
> While the fee-gougers are doubtless small in number, they have brought to the profession as a whole a certain degree of censure and criticism. If the medical professions, including the drug industry, are to preserve their private enterprise status in the years ahead, they must be careful to weed out all practices which give aid and comfort to their socialistic detractors.
>
> To recognize the need for putting and keeping our houses in order is to strengthen those traditional American forces that oppose the Truman-Ewing socialistic threat to our constitutional democracy.

Could be that before the birth of the grievance committees J. Q. Public poured his pet medical peeves into the ear of his neighborhood druggist, who was sympathetic but could not do much. Our new plan will be much better—if properly administered.

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

LET'S WIN THIS COLD WAR

There was a good bit of public rejoicing a few months ago when antihistamine pills first went on sale without a prescription. Recently we've noticed that some of that rejoicing has been replaced by vague doubts. "They say they aren't good for you" is typical of the remarks we've been hearing.

Usually it's a hard job to trace down the source of "they say" rumors. But in this case we feel reasonably safe in identifying "they" as official spokesmen of the American Medical Assn. The object of their current campaign is to get antihistamines taken off the drugstore counter and put back in the prescription department.

Here is what these spokesmen are saying: Antihistaminic drugs haven't been proved useful in treating colds and should be tested further. The layman hasn't the wisdom or experience to decide when he has a cold; cold symptoms may mark the onset of another disease. The "side reactions" of antihistamines are dangerous. The advertising of the nonprescription pills is misleading. (Perhaps it should be added here that the Amalgamated Mortuary Workers of America have voted antihistamine pills the "discovery of the year posing the greatest threat" to their industry.)

We suspect that the real purpose of the A.M.A. objections is to give the prescribing physician a monopoly on the first promising cold remedy that ever came along. And while we are not so presumptuous as to argue medicine with medical men, we think the objections can be answered.

The antihistamines now on sale have been tested —both as preventative and treatment in controlled investigations—by doctors in more than 6,000 cases. They have been tested to the satisfaction of physicians and pharmacists in the New Drugs Division of the Food and Drug Administration.

This division will not permit the public sale of any drug until it can "find no reason to believe it is not safe when taken in accordance with directions on the label, for the specific ailment described on the label."

The AMA people thus imply that the Food and Drug Administration has been careless and negligent in okaying the general sale of antihistamines. In doing so they cast unwarranted doubt on the safety of every medicine that the new drugs division has approved in its 13 years' existence. Yet they are concentrating their fire on only one preparation.

—*Colliers*

AMERICA'S RUSH FOR RESULTS WON'T SOLVE ALL THE PROBLEMS

Raised in the "get things done" tradition, we Americans are used to fast results in whatever we undertake. And we're impatient when we don't get them.

Yet, admirable as this approach usually is, there are times and places when it's really almost self-defeating. It can lead to concentration on immediate, short-run gains which not only fall short of the objective but may actually delay our reaching it.

The medical research field is an example. Today the scientists' big guns are trained on cancer, heart disease and polio, the most menacing and most puzzling ravagers of human health. To perform the experiments that will lead to cures and preventive measures, the researchers obviously need many millions of dollars.

A lot of that money is being made available to science. But specialists in the great university research centers often complain that too much of it is earmarked specifically for cure-seeking projects. It's almost as if contributions were labeled, "for finding a cancer cure by 1960."

Scientists point out, however, that the real cure for these dread diseases may lie in basic secrets of nature not yet unlocked. Projects devoted to applying already known medical facts are no help in unearthing them. They will only be learned through pure research—free swinging experimentation in the elemental processes of nature with no special object except to advance the frontiers of knowledge.

Medical researchers don't get enough of this kind of money. And if they don't get more gifts without strings, the real solutions we all desire may be much longer in coming than we imagine.

This urge to get results fast could be curbed a bit without hurting our record for energetic performance. In this we're all a little like the business man who has a reputation for working hard and is afraid to slow down. Our personal and national ego are involved. We think we have to achieve the millennium in our own lifetimes.

But after all we're only part of the stream of history. It's neither necessary nor possible that we shall stamp "solved" on every problem that now confronts us. Our successors will be perfectly capable of picking up where we leave off. More funds for pure medical research would be good evidence that we were beginning to take a more reasoned view of the future.

—*The Terre Haute Star.*

Just in Case You May Forget

1950 Annual Session

Indiana State Medical Association

FRENCH LICK

Sunday, Monday and Tuesday

September 25, 26 and 27

Write Direct to the Hotel for Your Reservation!

HOTELS AND RATES

French Lick Springs Hotel, French Lick, Indiana
(American Plan)

Single room with bath.....$14.00 per day
Double room with bath.....$12.00 per day per person
Double room with lavatory and toilet .....$10.00 per day per person
Double room with running water .....$ 9.00 per day per person
Parlors .....$12.00 per day

For those persons staying outside the hotel the meal rate will be: Breakfast, $1.50; luncheon, $2.00, and dinner, $3.00, including tickets for the banquet Wednesday night, September 27.

Check-out hours are 11:00 a.m. and 4:00 p.m.

Grand Hotel, French Lick, Indiana
(European Plan)

Rooms with bath on halls—
Double $3.00, $2.50, $2.00
Single $2.00, $1.50, $1.00

Claxton House, French Lick, Indiana
(European Plan)

Rooms with bath on halls—
Double $2.00
Single $1.50

West Baden Springs Hotel, West Baden, Indiana*
(European Plan)

Double room with bath.....$5.00 double; $3.00 single
Double room with toilet (no bath) .....$4.00 double; $2.50 single
Double room with running water only .....$3.50 double; $2.00 single

Be sure to specify type of accommodations, and time of arrival and departure.

Schedule of Events

MONDAY, SEPTEMBER 25

Instructional courses, Council and House of Delegates meetings, golf and trap shoot, party for women at night, and the big stag jamboree.

TUESDAY, SEPTEMBER 26

Scientific papers, morning and afternoon. Dancing at night to music of name band.

WEDNESDAY, SEPTEMBER 27

Scientific papers morning and afternoon. Final meeting of Council and House of Delegates. Annual dinner, with nationally-known humorist as principal speaker.

* West Baden Springs is one mile from French Lick

THE CARELESS WORD

THOUGHTLESS disregard of other people's feelings or needs is a facet of selfishness which continually works great harm, while those who are habitually thoughtful of others stand high in the esteem of all. Such thoughtfulness seems natural in some, but it can be acquired and augmented, as witness the trained nurse and, in most cases we hope, the physician.

At any rate, a doctor editor of a state medical journal has observed thoughtlessness in action, and since he is thoughtful of the feelings and morale of a certain sensitive type of patient he has written the following editorial. After reading it you may wish to show it to the editor of your local paper or to the head of your county Cancer Society. Proceed:

'THE SEMANTICS OF CANCER

'In a *Treasury of Great Reporting*, Rebecca West speaks of a fascist pamphlet in these striking terms: "It was as if a man walked in with his clothes held open to show a cancer." This may be great reporting but to a cancer patient and his family, it is like being struck with a whip. The word "cancer" has become the rubber stamp which unimaginative writers use in lieu of thinking up a more descriptive term. While it does save wear and tear on the writer's brain, it's cruel reading for cancer patients.

'A random sampling of a few newspapers shows the following examples of this cliche:

"Douglas told the Senate that the country's slums were a moral cancer."

"Marquand confesses that this fails to assuage the cancer of an inferiority complex."

"The Attorney General said that this cancer in the body politic should not be covered up."

"Advocating expulsion of communists from the C.I.O., Reuther said that the body politic has a cancer and that we have to save either the body or the cancer."

"Our divorce laws aggravate an already cancerous condition in our society and morals."

"The Far East is so riddled by the malignancy of poverty and ignorance as to. . . ."

"Heavy sentences in the gambling cases will combat this cancerous condition in New Jersey."

"Europe cannot preserve its civilization with this cancer at its edge."

"The cancer of discrimination is a threat to the American ideal."

"The current tendency to defame public officials is a dangerously growing cancer."

'Here then are ten samples, selected from newspapers within a few weeks. Do you think it took a fine comb to go through the papers and make these selections? No. A patient who had had a cancer removed picked the phrases out without half trying. To him, the word "cancer" leaps out of the printed page and hits him in the eye—and in the heart, too. With commendable courage, he has persuaded himself that cancer is not necessarily malignant, that it can be cured and that in his case, it has been cured. Must he continue to see the word flaunted daily as a symbol of hopeless malignancy?

'We can do better than that. The word is a stereotype. It lacks freshness. It is overworked and inaccurate. And there are too many cancer patients in this country to permit us to sting them with this simile.

'The writers who wallow in this hackneyed comparison do not intend to be cruel. They do not know what they are doing to the patient, and we must therefore forgive them. But someone must call attention to the caustic effect of their carelessly chosen cliche. They must be reminded that it is agonizingly jarring to every cancer patient and to all his loved ones. Since no one seems to have said it before, let it be said now: the word "cancer" must no longer be used as a synonym for everything nasty, malignant or corrupt. It can be a word of hope if only the writers will return it to the dictionary and use some less trite and less tormenting a term. This is surely the least they can do on behalf of one of the most gallant of our fellow-citizens—the courageous cancer patient.'—*Journal Medical Society of New Jersey*, March, 1950.

RESOLUTION COMMENDING THE INDIANA STATE MEDICAL ASSOCIATION FOR ITS CONSTRUCTIVE ATTITUDE IN PREVENTIVE MEDICINE AND PUBLIC HEALTH

AT THE fourth annual conference of the Indiana Public Health Association the following resolution was adopted:

WHEREAS the Indiana State Medical Association has recognized the need of a rural health program in solving many of the health problems of rural communities; and

WHEREAS it has appointed a committee of which Dr. Frank G. Sink is its active chairman; and

WHEREAS included in the membership of the State Rural Health Committee is Dr. F. S. Crockett, head of the Rural Health Committee of the American Medical Association; and

WHEREAS the Indiana State Medical Association has recognized the problem of the cost of medical care; and

WHEREAS it has attempted to solve this problem by lending its support to the creation of the Blue Shield Insurance Company; and

WHEREAS the State Medical Association has definitely gone on record as favoring full-time health departments; and

WHEREAS the Indiana State Medical Association has created a Committee on School Health and Physical Education and has set up regional conferences in an attempt to solve problems surrounding school health and physical education; and

WHEREAS the Indiana State Medical Association has constantly strived for a high standard of medical education and care: Now, therefore,

BE IT RESOLVED, that the Indiana Public Health Association wishes to commend the Indiana State Medical Association for its constructive activities in the field of preventive medicine and public health and in solving the various problems enumerated above; and

BE IT FURTHER RESOLVED, that a copy of this resolution be sent to the press and to the Indiana State Medical Association.

Deaths

David A. Morrison, M.D., of Kokomo, was killed in an automobile accident as he was returning to Kokomo from Indianapolis, on April 19. He was fifty-four years of age. He was a graduate of Indiana University School of Medicine, in 1924, and had practiced surgery in Kokomo since 1926. Doctor Morrison was a veteran of both World Wars, with active service in World War II as a medical officer in the Southwest Pacific, attaining the rank of commander. He was a member of the Howard County Medical Society, the Indiana State Medical Association, a Fellow of the American Medical Association, and a member of the International College of Surgeons.

Harry A. Washburn, M.D., retired physician of Waldron, died on April 24, at the age of seventy-six. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1897, and practiced in Fortville for forty years before he retired.

Joseph M. Glenn, M.D., retired physician of Vincennes, died in Petersburg on April 13, after a long illness. He was seventy-nine years old. He was a graduate of the Kentucky School of Medicine, in Louisville, in 1902, and had practiced in Decker before moving to Vincennes.

Clarence A. Hartley, Sr., M.D., of Evansville, died suddenly on April 7, at the age of seventy-six. He was a graduate of the George Washington University School of Medicine, in Washington, D. C., in 1907, and had practiced in Evansville since that time. Doctor Hartley was an Honorary member of the Vanderburgh County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Dwight Pitkin, M.D., of St. Louis, drowned on May 8, while on a vacation in West Palm Beach, Florida. He was twenty-two years old. Doctor Pitkin was the son of Dr. Edward M. Pitkin, of Martinsville, and was resident surgeon at the St. Louis City Hospital.

John S. Spoor, M.D., former physician at the Indiana Boys School in Plainfield, died in Fort Lauderdale, Florida, on May 2, at the age of eighty-three. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1901, and practiced in Brooklyn before going to Plainfield. Doctor Spoor retired in 1935, when he moved to Florida.

Letter to the Editor

While most informed medical men are perfectly aware of the forces at work to socialize medicine, only a few seem to realize that, aided and abetted by most of our teaching institutions and several well-organized medical political groups, the American Medical Association appears to be well on the way to building itself a "board" casket.

Medical practice as we have known it in the United States can commit suicide in no quicker or surer way than by educating all young doctors that the only possible key to success is an American Board certificate. Yet a recent survey of leading medical teaching centers has shown that only a mere fraction of all students are planning for anything else.

These men have been led to believe that a man without a board is indeed a man without a country or a future, and that such a man is very likely to find himself unable to obtain hospital staff appointments or even to make a living if he dares venture out into the world without a certificate.

Unfortunately in some parts of the country action by members of certain certified groups in attempting to bar others from hospital staff appointments has given some basis for this fear. Only recently, however, the American Board of Surgery has gone on record as saying:

> "The American Board of Surgery is not concerned with measures that might gain special privileges or recognition for its certificants in the practice of surgery. It is neither the intent nor has it been the purpose of the Board of Surgery to define requirements for membership on the staffs of hospitals."

Also, a report of the Council on Medical Education and Hospitals of the A.M.A. states:

> "It was never intended that staff appointments in hospitals generally, or even in hospitals approved for residencies, should be limited to board-certified physicians."

With these statements in mind it becomes at once apparent that our young men are being misled and that something must be done to correct the situation.

At a time when the threat of socialization and lay political control hangs heavy over our heads it behooves every man to remember that medicine is not an exact science but, after all, one of the true arts.

It is time for us to recognize that no system of education, however lengthy or complex, can turn out a finished product, and surgeons, internists, et cetera, are no more turned out of a crucible than are Mozarts, Rembrandts and Pasteurs.

That our system of medical education, residencies, more residencies, and more and more training is being carried to the point of absurdity can be no more clearly demonstrated than by the recent attempt of a great midwestern university to promulgate, of all things, a three-year residency in general practice.

Now, when the greatest need in medicine is for the good general practitioner, we are training more and more specialists and telling our students that they should belong to this or that group. Schools point with pride to the high percentage of their graduates who are certified. The result can only be group practice, and group practice is very likely to mean government support in some form or other.

If the private practice of medicine as we have known it in this country is to survive, we must at once provide the general men for which there is such a crying demand and at the same time make it possible for them to attain medical stature by some means other than institutional training.

In days past it has been possible for a young doctor to associate himself with an older man in practice and by diligent observation and application attain a high degree of medical or surgical proficiency. Today such training is hardly recognized at all, because without a certain number of years of hospital training it fails to lead to a board certificate.

Experience is the best of teachers in every field, and for those men who would begin practice after only a year or so of hospital training following graduation the door to further achievement must not be closed.

We believe, therefore, that a definite break of from three to five years in the training of every specialist should occur and that this time should be spent in general practice. Such a plan would do much to overcome the trend to over-specialization; quickly make up the existing deficit in general practitioners; enable a far greater percentage of men to find their own rightful field in medicine; and lastly to aid in warding off the threat of socialization which is being brought about in many sections of the country by the lack of men in general practice.

Almost every specialist of the old school is well aware of the value of his early training in general practice and if we can give our boys one year of internship, followed by three to five years in general practice, we will have added much to the stature of the finished product and at the same time have solved an acute medical problem.

W. L. Green, M.D.
Kalamazoo, Mich.

News Notes

DEAN VAN NUYS HONORED BY PUBLIC HEALTH ASSOCIATION

A singular honor was conferred upon Dr. John D. Van Nuys, dean of the Indiana University School of Medicine, by the Indiana Public Health Association when he was selected for the Distinguished Service Award in Public Health.

Doctor Van Nuys was the first person to receive the award. It will be presented every year to some Indiana person for outstanding work in the field of public health.

In presenting the award to Doctor Van Nuys at the association's banquet on April 17, Mrs. Montgomery Lewis, chairman of the Awards Committee, said, in part:

TO DR. JOHN D. VAN NUYS . . .

Who, as Dean of Indiana University School of Medicine, has done much to raise the quality and scope of the Medical Center . . .

Who has increased the number of medical students to meet the demand for more physicians in spite of limited facilities and staff and yet at the same time has raised the quality of medical education . . .

Who has recognized the need for full-time faculty members and has secured outstanding men in the various specialties to come to Indiana . . .

Who has placed vigorous emphasis upon the importance of research in the progress of medicine and its essentialness in providing quality medical training . . .

Who, being keenly aware of the need for continued education of the graduate in medicine in order that the public may receive the highest quality medical care, has established a postgraduate education program for all areas of medicine . . .

Who has given encouragement and support to further developments in the School of Nursing and to the activities of the Social Service Department of the Medical Center . . .

Who has demonstrated his awareness of the need for better training of the undergraduate student in preventive medicine and public health, by supporting the School's Department of Public Health . . .

For these and many other accomplishments, the Indiana Public Health Association is proud to choose Doctor Van Nuys as the first recipient of the *Distinguished Service Award in Public Health.*

Dr. J. B. Carr, Indianapolis dentist, was elected president-elect of the association. Mrs. Roberta Nicholson, also of Indianapolis, is now serving as president.

SEVENTH NATIONAL CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS

Sunday, June 25, 1950

Palace Hotel—San Francisco, California

Tentative Program Outline

9:00 a.m. Registration

9:20 a.m. Call to Order—A. M. Mitchell, M.D., Chairman, Terre Haute
Opening Remarks of Welcome by Member of the Board of Trustees

Morning Session

9:30 a.m. I. What Do You Know For Sure?
A true and false questionnaire on socialized medicine to be given to everyone in the audience with 20 minutes allowed for answering. At the end of this period the papers will be collected and corrected during the remainder of the program. Results will be announced at the end of the morning session.

10:00 a.m. II. How To Set Up A County Medical Society Record System
a. 20 minutes of presentation
b. 20 minutes for discussion

10:40 a.m. III. How To Organize A Community Health Council
a. 30 minutes of presentation
b. 30 minutes of discussion

11:40 a.m. IV. Providing Special Benefits Through County Medical Society Membership (such as Group— A & H, Malpractice, Medical and Hospital, and Life)
a. 20 minutes of presentation
b. 20 minutes of discussion

12:20 p.m. V. Results of Quiz

Evening Session

8:00 p.m. I. The Third Party In The Practice of Medicine (This refers to insurance companies, hospital and medical care plans, etc.)
a. 20 minutes of presentation
b. 20 minutes of discussion

8:40 p.m. II. Hospitals and The Practice of Medicine
a. 20 minutes of presentation
b. 20 minutes of discussion

More than a hundred Indiana physicians and their wives are planning to attend the annual meeting of the American Medical Association in San Francisco on June 26, 27, 28, 29 and 30.

Approximately 75 persons have signed for the sight-seeing tour sponsored by the Indiana State Medical Association. It will cover 5,500 miles and sixteen states. The party will leave Indianapolis and Chicago on Saturday, June 17, spend two days in Glacier National Park, and will stop for two days at Seattle, Washington, from which Victoria, B. C., will be visited by ship one day and a trip taken to Mount Rainier the next day.

The Hoosier group, traveling in their own Pullman cars, will reach San Francisco Sunday noon, June 25, and leave at noon on Friday, June 30, for Denver, Colorado. On the return trip 24 hours will be spent at Denver. The party will reach Chicago and Indianapolis on Monday, July 3.

The price of the tour includes lodging in hotels five nights (not while in San Francisco), six nights in Pullmans, seven meals in Glacier National Park and all sightseeing transportation. Reservations for the tour are being made through the state association office.

Dr. A. M. Mitchell of Terre Haute will preside at the seventh National Conference of County Medical Society Officers in the Palace hotel on Sunday, June 25. The program will be a discussion forum on subjects of particular interest to county medical society officers. The Conference of Presidents, for officers of the state medical associations, will be held in the Palace hotel the same day.

Mrs. Truman E. Caylor of Bluffton, immediate past president of the state Woman's Auxiliary, is to give the response at the opening session of the national Woman's Auxiliary meeting.

The meetings of the House of Delegates will be held at the Palace hotel. Indiana's delegates are Dr. F. S. Crockett of Lafayette, Dr. Homer G. Hamer of Indianapolis, Dr. William M. Cockrum of Evansville and Dr. A. S. Giordano of South Bend. One important decision to be made by the delegates is the amount of active membership dues for 1951.

More than 10,000 physicians are expected at the meeting. More than 300 papers devoted to medical and surgical progress will be presented by outstanding physicians from all over the world.

Dr. Elmer L. Henderson of Louisville, Kentucky, will be installed as president of the American Medical Association on June 27. The presidential ball will be held on Thursday night, June 29, at the Palace hotel.

The second annual convention of the **International Academy of Proctology** will be held at the Bellevue Hotel in San Francisco June 23 and 24. Further information concerning the convention and a copy of the program may be obtained from Dr. Alfred J. Cantor, Secretary, International Academy of Proctology, 43 Kissena Boulevard, Flushing, New York.

The third annual Industrial Microbiology short course will be held on the Purdue university campus from June 19 to July 1. An intensive two-weeks program is being planned for research and production directors in microbiology laboratories, technicians, as well as a refresher course for college teachers and research workers. Additional information may be obtained by writing to Dr. C. L. Porter, School of Science, Purdue University.

A resolution opposing compulsory sickness insurance was adopted by the Indiana Tuberculosis Association at its annual conference in Indianapolis on May 10. The tuberculosis association is the first Indiana state-wide voluntary health organization to take such action.

Dr. E. W. Custer of South Bend was succeeded as president by W. Guy Brown, Decatur school superintendent. Dr. Harold D. Caylor of Bluffton was named first vice-president, and Dr. C. J. McIntyre of Indianapolis was re-elected treasurer, with Dr. John V. Thompson of Indianapolis selected as assistant treasurer.

New officers of the Indiana Trudeau Society, which is the Medical Section of the Indiana Tuberculosis Association, are Drs. H. L. Murdock, Fort Wayne, president; Horace Wanninger, Richmond, president-elect; Joseph W. Strayer, Lafayette, vice-president, and C. J. McIntyre, Indianapolis, secretary-treasurer.

Dr. James C. Sargent, Milwaukee, chairman of the Council on National Emergency Medical Service, was among the 70 distinguished citizens attending the Secretary of Defense's sixth joint orientation conference at Fort Benning, Georgia, recently. The conference was designed to acquaint leaders of industry, business and government with the nature of the military on a tour which covered various armed forces installations.

Doctor Sargent was quoted in the Columbus, Georgia, *Inquirer* as saying that immediate civil emergency defense measures must be taken. This, he pointed out, requires organization of civil defense on a regional basis rather than on a local level since target areas might be wiped out. He said two things must be accomplished: (1) The nation's doctors must be advised on the unusual medical aspects of atom warfare, and (2) the civil defense movement must be speeded.

Dr. Joseph B. Davis, of Marion, has been appointed as a consultant in surgery at the Veterans Administration Hospital in Marion. He recently passed the American Board of Surgery.

Dr. Michael Shellhouse, of Gary, was recently appointed a member of the State Board of Medical Registration and Examination by Governor Schricker.

Dr. R. E. Mitchell, formerly of Indianapolis, now serving full time with the Marine Service, is stationed at O'Reilly General Hospital in Springfield, Missouri.

Dr. James S. Fitzpatrick, a native of Bloomfield, became associated in the practice of medicine and surgery with **Dr. Donald E. Spahr** at Portland in April. Doctor Fitzpatrick is a 1944 graduate of the Indiana University School of Medicine, and after interning at Indianapolis General Hospital, spent two years with the U. S. Army Medical Corps, more than eight months of which were spent in Japan. Following his release from service he served a three year residency in surgery at the Methodist Hospital in Indianapolis.

Four Indiana physicians appeared on the program of the 1950 annual session of the Nebraska State Medical Association at Lincoln, Nebraska, on May 3. They were **Drs. Lyman T. Meiks, John A. Campbell, Carl P. Huber** and **Sprague H. Gardiner**, all of Indianapolis.

Dr. E. Rogers Smith, of Indianapolis, addressed the state convention of the Arkansas Medical Association in Fort Smith, Arkansas, on April 18. He read a paper on "Discussion of State Hospital Problems."

Dr. Dan L. Urschel, of Mentone, recently received the degree of Fellow of the American College of Physicians in Boston.

Dr. Boynton Booth, of Indianapolis, recently completed a residency in dermato-syphilology at Indianapolis General Hospital, and is now taking advanced training in dermal pathology in St. Louis. He was recently certified by the American Board of Dermatology and Syphilology, and plans to return to Indianapolis in July to practice dermatology.

Dr. Robert E. Jenkins, of Indianapolis, has been certified by the American Board of Dermatology and Syphilology. He recently completed a residency in dermato-syphilology at Indianapolis General Hospital, and is now in practice at 707 Hume Mansur Building, Indianapolis.

Dr. H. G. Kobrak, of Gary, has been elected as an honorary member of the Chilean Society of Otolaryngology and of the Otolaryngological Society of Peru.

Recent elections of officers and directors of Mutual Medical Insurance, Inc., resulted in the following: Directors to serve for three years: W. H. Howard, M.D., of Hammond, R. R. Calvert, M.D., of Lafayette, E. H. Clauser, M.D., of Muncie, W. Lawrence Daves, M.D., of Evansville, I. C. Barclay, M.D., of Evansville, M. B. Cattlett, M.D., of Fort Wayne, and Mr. H. D. Newsom, of Columbus. Officers of the company were re-elected for one year: W. U. Kennedy, M.D., New Castle, president; W. H. Howard, M.D., Hammond, vice-president; W. L. Portteus, M.D., Franklin, secretary; and A. F. Weyerbacher, M.D., Indianapolis, treasurer.

At the annual meeting of the **Indiana Academy of General Practice**, on April 19, in Indianapolis, Dr. Maurice V. Kahler, of Indianapolis, was installed as president. Dr. Clarence Rommel, of West Lafayette, was elected president-elect for 1951, and Dr. Erwin Blackburn, of South Bend, was chosen vice-president. Drs. William Tindall, of Shelbyville, Walter Portteus, of Franklin, Michael Shellhouse, of Gary, and Nathaniel Isler, of Jeffersonville, were appointed to the board of directors. Drs. O. T. Scamahorn, of Pittsboro, Clarence Herzer, of Evansville, N. R. Booher, of Indianapolis, and G. W. Herrold, of Lafayette, were appointed as delegates to the American Academy of General Practice.

A summer camp for diabetic children will be conducted for the second season under the auspices of The Chicago Diabetes Association, Inc. at Holiday Home, Lake Geneva, Wisconsin, from August 8 to August 29. In addition to the regular personnel of the camp, there will be a staff of dietitians and resident physicians, trained in the care of diabetic children, furnished by The Chicago Diabetes Association.

Boys and girls, ages eight to fourteen years inclusive, will be accepted at a fee of $120 (which covers three weeks camping and transportation from Chicago). Fee reductions may be arranged according to circumstances. Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend. Correspondence should be addressed to The Chicago Diabetes Association, 950 East 59th Street, Chicago 37, Illinois. Limited capacity requires prompt application.

A.M.A. WASHINGTON OFFICE NEWS

More Atomic Warfare Courses On Schedule. The nation-wide effort to familiarize *all physicians* with medical aspects of atomic warfare is in full swing, with five top level instruction courses completed, one more underway this week, and a final one scheduled for May. The one-week courses are sponsored jointly by *Atomic Energy Commission* and *National Security Resources Board.* Geared into the program are the A.M.A.'s Council on National Emergency Medical Service and state medical societies, many of which already have started programs to indoctrinate members in radiological injuries and treatment.

The program is based on the *"filtering down"* principle. For the initial courses, quotas are set for states, and attendance kept at a level that allows for *individual instruction* and *laboratory observation.* Only highly-qualified physicians are selected for these courses and a prerequisite is *ability to teach* and *definite interest* in spreading this information. Enrollees are appointed by state governors, acting on the advice of representatives of medical societies, state officials and medical college deans.

Courses on *two lower levels* will follow. In the first of these, the 100-odd physicians who complete the current courses will conduct two-day courses for smaller groups, again men who have demonstrated the ability and willingness to spread the knowledge even farther. Finally, this last group will schedule their own lectures on medical aspects of atomic warfare, with the objective of eventually reaching every physician in the country.

McIntire Heads Red Cross Blood Program Committee. Dr. Ross T. McIntire has been named chairman of the Committee on Medical Policies and Procedures, National Blood Program of the Red Cross. This is an independent committee, which will handle policy-making for the blood program. Dr. Louis K. Diamond of Harvard Medical School is medical director of the blood program. Members of Dr. McIntire's committee are Drs. Isadore S. Ravdin, University of Pennsylvania; Charles Doan, Ohio State; Carl Moore, Washington University of St. Louis; and Charles A. Janeway of Harvard.

First Returns Received On Income Questionnaire. Four days after first questionnaires were mailed out, returns started reaching Commerce Department on the physicians' income survey. It is expected that the first round of questionnaires will be in the mail within the next two weeks. The A.M.A.'s Bureau of Medical Economic Research, which is cooperating with Commerce Department in the survey, has strongly urged every physician to fill out his return and mail it back promptly. The Bureau is particularly anxious to get returns from physicians who do not employ bookkeepers or financial secretaries. There is a possibility that returns from previous similar surveys have been thrown out of balance by a high percentage of replies from physicians who are in a position to have an assistant fill out the forms.

Survey Shows Tuberculosis Death Rate Falls 10 Percent. The tuberculosis mortality rate in the United States declined 10 percent in 1948, according to a survey by Public Health Service (Reports, Vol. 65, No. 14). Although the trend of mortality has been down for more than 30 years, *the 10 percent decline is the best ever recorded.* PHS also points out that this progress was made despite more effective techniques for reporting the disease. The report notes that although almost all age groups have shared in the decline in respiratory tuberculosis mortality, the largest percentage decrease has taken place among children under 15 years of age. At the same time, the survey indicates that tuberculosis is becoming a relatively more important cause of death in the *young adult ages.* One other conclusion is that in general the death rate for nonrespiratory tuberculosis has declined more rapidly than the rate for respiratory forms. . . . A highlight of National Tuberculosis Association meeting in Washington was announcement that approximately 14 million Americans had been x-rayed in tuberculosis screening tests in 1949. . . . At same meeting, announcement that Washington, D.C., plans "multiphasic screening" project which will test hundreds of persons daily for tuberculosis, heart and blood diseases, diabetes, syphilis, vision and hearing and other defects.

Indiana University News Notes

Acceptance of 150 students for admission to the Indiana University School of Medicine next fall, comprising one of the largest entering medical classes in the country, was announced recently by Dean John D. Van Nuys.

Selected after months of study and interview, the members of the class are all Hoosiers except six. One-third of them are from small towns and rural areas. The six out-of-state students were chosen from a large number of applicants in accordance with the medical school's policy of reciprocating the action of medical schools in other states in accepting Hoosiers. Last year 60 Indiana residents attended out-of-state medical schools.

The class of 150 is the third of that number admitted to the school as a step toward meeting the need for more physicians and as a means of taking care of the qualified in-state applicants. Normal entering classes in the school number 128 students.

Dean Van Nuys said that while final figures were not yet available, it is expected that only three or four of the country's 78 medical schools will admit a larger number this year than Indiana. All of those admitted by Indiana University will have completed by September at least three years of prescribed work in an approved college.

Approximately 600 Indiana applicants were screened in the selection of the class by an admissions committee composed of 16 faculty members. The selections were made on the basis of scholarship, results of the national medical aptitude tests, physical fitness, emotional stability, character recommendations, and personality.

Students admitted are as follows:

Harold Askren, Robert E. Bakemeier, Richard C. Boling, Rolan R. Botkin, James R. Brillhart, Charles W. Dill, Paul M. Eicher, Carolyn Harvey, Stanley J. Klos, Jr., William W. Lee, Robert W. Mouser, John M. Nohl, Carol E. Query, Richard C. Raines, Jr., Jack A. Schecter, Robert L. Stevenson, Alfred D. Weiss, and Garth E. Widdifield, all of Indianapolis; Reginald R. Barton, Robert G. Chappell, Robert L. Hast, Harold V. Johnson, John W. Roper and Carl H. Sutton, Evansville; Frank A. Beardsley, Jr., and George E. Hamilton, Frankfort; Jack F. Beineke and Charles W. Freeby, Decatur; Donald R. Bennett, John J. Bergan, Guy C. Mark, Rodney R. Million, Thomas R. Pauszek, Thomas A. Rafalski, Mona Mary Rice, South Bend; Leslie E. Bombar, Frank R. Brueckmann and Nicholas L. Poletis, Hammond; Philip G. Bowser and Chester L. Edwards, Goshen; Charles F. Bradley, Robert A. Danieleski, James A. Fleming, Gerald R. Nolan, Leslie D. Olson, and Charles S. Warner, Gary;

Forrest R. Buell, Bowling Green; Joe B. Butler, Crothersville; John D. Carney, Jeffersonville; James B. Carpenter, Mooresville; James R. Carpentier and John H. Phillips, Princeton; Robert C. Childress, Fowler; George A. Clark, New Augusta; Floyd E. Colvin, Salem; Richard D. Connelly, Paul J. Nichols, Francis E. O'Brien, James J. Schaffer, Phyllis Jean Seal, Jack L. Shanklin and Byron C. Wheeler, Jr., Terre Haute; Robert F. Cottrell, Fremont; John R. Coughenour and James H. Tower, Jr., LaPorte; Thomas J. Covey and Andrew J. Gyure, Jr., Whiting; Thomas V. Craig, Richard C. Fretz and William A. Reed, Kokomo; Gilbert L. Dehne and Henrietta Moritz, Michigan City; Byron C. Doran, Burket; Michael J. Dugan, North Vernon; Mark L. Dyken, Jr., and Andrew D. Spencer, East Chicago; Joe C. Ebbinghouse, North Manchester; Frank H. Eisenhardt, Warsaw; Donald L. Fields and Warren E. Stibbins, Muncie; Dallas B. Fouts and Paul J. Wenzler, New Albany; Donald B. Garvin, Brazil; Robert K. F. Gibson, Batesville; James S. Glenn, Sheridan; Bernard A. Grangier, Bedford; Charles R. Gumpper, Lewis E. Smith, Jr., Danny D. Swihart and Richard J. Weaver, Elkhart; Charles E. Gunnoe, Clinton; Walter G. Hackett, Jr., Stephen Y. Klingler, Myrle F. Marsh, Jerome C. Schubert, William D. Seidel, Sheldon D. Stern, Fred C. Tucker and Willo F. Ungemach, Fort Wayne; Richard D. Hansen, John G. Haywood, Dixon L. Hughes, Joe R. Lloyd, Robert J. Morrow, Donald B. Reid, and Thomas F. Wooden, Bloomington;

Marshall F. Hall and Meredith Ann Holsinger, Garrett; Gilbert S. Hamilton, Richmond; Glen E. Hawkins, Culver; Max N. Hoffman, Cory; Edgar E. Hurst, Jr., Greencastle; George E. Kimmel, Thorntown; Robert S. Kincaid, Richland; Ronald G. Kleopfer, Madison; Herbert Kwittken, John Kwittken and Edith McGuire, Marion; Jack L. Lenox and George S. Porter, Lebanon; Charles L. Miller, Crawfordsville; John S. Murray, Jr., Vincennes; John F. O'Brian, Loogootee; Ross A. Overley, Monticello; Dean M. Hall and Thomas N. Petry, Anderson; Edward D. Plasterer and Marvin E. Priddy, Huntington; Phyllis Roggenkamp, Milltown; Malcolm L. Rusk, Wallace; Edward C. Shipley, Crown Point; Richard L. Shoemaker, Lafayette; Phyllis Shroff, Nashville; Omer T. Slough, Bourbon; John H. Smith and Michael L. Yacko, Mishawaka; John O. Smith and Jerome H. Wait, Columbia City; Hugh A. Stallings, Rockport; Charles H. Steinmetz, Shelbyville; Harold E. Stoner, Ladoga; Robert D. Stout, Brookville; Carl A. Trees, Greenfield; Ralph D. Weller, Dale; William C. Filsinger, Toledo, O.; Burton L. Nackenson, Bronx, N. Y.; Jack N. Rosenberg, Philadelphia, Pa.; Kamal S. Sheena, Ann Arbor, Mich.; Harry Wogalter, Brooklyn, N. Y.; and Dionysios S. Botseas, Athens, Greece.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

April 16, 1950

The council of the Indiana State Medical Association convened for its spring meeting at 10:10 a.m., Sunday, April 16, 1950, in the Columbia Club, with Dr. W. U. Kennedy, chairman, presiding.

Roll call showed the following present:

Councilors:

First District_____Herman T. Combs, Evansville
Second District_____William C. Reed, Bloomington
Third District_____William H. Garner, New Albany
Fourth District_____George A. May, Madison
Fifth District_____A. M. Mitchell, Terre Haute
Sixth District_____W. U. Kennedy, New Castle
Seventh District_____C. J. Clark, Indianapolis
Eighth District_____E. H. Clauser, Muncie
Ninth District_____Wemple Dodds, Crawfordsville
Tenth District_____William H. Howard, Hammond
Eleventh District_____Elton R. Clarke, Kokomo
Twelfth District_____M. B. Catlett, Fort Wayne
Myron L. Habegger, Berne, alternate
Thirteenth District_____Kenneth L. Olson, South Bend

Officers:

C. S. Black, Warren, president
Alfred Ellison, South Bend, president-elect
A. F. Weyerbacher, Indianapolis, treasurer
Frank B. Ramsey, Indianapolis, editor of THE JOURNAL
Walter L. Portteus, Franklin, chairman, Executive Committee
Albert Stump, Indianapolis, attorney
Ray E. Smith, executive secretary
James A. Waggener, field secretary

Guests:

Cleon A. Nafe, Indianapolis, chairman, Indiana A.M.A. Campaign Coordinating Committee
J. William Wright, Indianapolis, co-chairman, Legislative Committee
Norman R. Booher, Indianapolis, chairman, Technician Training Study Committee

On motion of Drs. Mitchell and Clauser, the minutes of the midwinter meeting of the Council, held at Indianapolis on January 15, 1950, were approved as printed in the March, 1950, issue of THE JOURNAL.

Special Announcement

The chairman announced the resignation of Dr. C. J. Clark, Indianapolis, Seventh District councilor.

Reports of Councilors

District meeting dates were announced and legislative activities in the various districts were discussed by each of the councilors.

Doctor Combs, First District, told of the recent formation in Evansville of The American Way, an organization to fight socialistic legislation, in line with the suggestions of Whitaker and Baxter and in conjunction with the A.M.A.'s public relations program. "Practically everything in the district is represented in this organization—industry, labor, farm cooperatives, teachers, schools, lawyers, farmers, dentists and physicians—everyone but the CIO. The AF of L came in."

Doctor Reed, Second District, spoke of the essay contest which the Owen-Monroe County Medical Society had sponsored during the past month. In addition to some national prizes, the Owen-Monroe Society set up a fund of its own to encourage local students to participate.

Our representative in congress, James Nolan, has made a complete about-face since the time of his election. At that time he announced that he had been elected by the people who favord socialized medicine and therefore would vote for it. Later he stated that he was not for socialized medicine, but did not consider the bill in congress socialized medicine. Just before the primary he came out flatly against any form of government-sponsored medicine. Each doctor in his district received a personal letter from him, in which he stated that he felt it would not be for the best interests of the people to adopt pending legislation and that he was definitely opposed to any form of government-sponsored insurance. I believe our educational campaign is bearing fruit.

Doctor Clauser, Eighth District: "The Woman's Auxiliaries in the Eighth District are meeting this week and are organizing themselves on a district level. Quite a bit of interest has developed and they feel they can do something on a district level."

Doctor Elton Clarke, Eleventh District, said the response to his inquiry about the graduate education program had been very good, with Peru being the indicated choice of place for such a meeting. He expressed the feeling that attendance probably would not be high this late in the spring and probably a fall date would be a better time. . . . The Howard County Medical Society is sponsoring a radio program over the Kokomo station, entitled, "Meet Your Doctor."

Doctor Catlett, Twelfth District, announced the election of Dr. Myron L. Habegger, of Berne, as alternate councilor for the Twelfth District, at the district meeting held in Fort Wayne on April 4, 1950.

The chairman introduced Doctor Habegger at this time.

Reports of Officers

DR. C. S. BLACK, president 1950: "The various committees that I have named have been functioning admirably, meeting often, and accomplishing things. They really have been quite active in

the organization of this state society. Another thing that I think we can't neglect and that is to compliment the Auxiliary for all the work they have done. They have enlarged their membership from 900 to over 2,000 members in the last year, under the capable leadership of Mrs. Caylor. . . . I see she has been recognized to give the response at the A.M.A. meeting at San Francisco in June.

"Another thing that was brought out last night by the state office . . . on this advertising campaign only 23 percent of the societies had functioned in taking this to the various papers. That's deplorable, when you can get only 23 percent out of 100 percent to show some interest in their own welfare.

". . . We must observe diligence and perseverence about the candidates for Congress. . . . Now this thing won't get through this session of Congress, but those fellows are elected for another session, so you can't ignore that.

"I think we cannot ignore a lot of these things. There is this thing about it all, if you don't enter politics, politics is going to enter medicine. It is going to be one way or another. I am going to ask each and every one of you to pay more attention, and to see that your district and your county medical society officers pay more attention, to this matter."

DR. ALFRED ELLISON, president-elect: "As you know, this year my general function is to be understudy to Doctor Black, and I am sure you all know what a pleasure it is to be associated with such a grand leader. Since I was not able to be present at the last meeting of the Council, I want to express my sincere appreciation to the members for the many courtesies and considerations shown me during my three years as chairman."

DR. A. F. WEYERBACHER, treasurer, gave a report of the bank balances on hand as of April 15, 1950, in each of the checking accounts of the association.

DR. FRANK B. RAMSEY, editor of THE JOURNAL: "We are now making plans for the year book issue of THE JOURNAL, which will be the July issue. It will contain the customary registrations and lists and informational data that we have always had. In addition to that, we have been talking with Mr. Stump about some medico-legal articles. One is to be written on the legal aspects of artificial insemination. It also has been suggested that it might be well if he could write a short article upon the status of the doctor in caring for a welfare family. When you call to see a private patient, you are not required to see any other members of his family unless you are requested to see them. In the case of a welfare family, your responsibility extends to other members of the family. These are the only two subjects we have so far. We do not need a lot of articles to fill this number but we would be glad to have your suggestions on any other subjects that you think might be of interest."

DR. W. L. PORTTEUS, chairman, Executive Committee, presented the following matters for consideration of the Council:

(1) *The purchase of single certificates in Blue Cross and Blue Shield* for the employees of the headquarters and THE JOURNAL offices, to become effective June 1, 1950, at a cost of $168.00 a year, was approved by the Executive Committee at its meeting on March 5, 1950. On motion of Drs. Howard and Elton Clarke, the Council also approved this action on the part of the association.

(2) *Standards of approval for disability insurance.* The proposal of the Disability Income Insurance Company of Indianapolis to set standards for health and accident insurance was discussed at the midwinter meeting of the Council but no action was taken. The Executive Committee, at its meeting on March 5, 1950, approved the setting up of such standards and referred this matter to the Council.

Doctor Portteus said the Executive Committee feels that a committee should be appointed to study this program, with the idea of setting up standards for health and accident policies. Dr. C. J. Clark explained that if standards are established, it will take very little of the physician's time to evaluate an accident or health insurance policy for himself or for his patients.

On motion of Drs. Mitchell and Howard, the chairman of the Council was directed to appoint a committee to continue the study of this matter and refer it back to the Council at the next Council meeting. The committee, when appointed, is to be asked to distribute its findings to the Council prior to the next Council meeting.

(3) *Proposed CIO policy statement on voluntary prepaid medical plans.* A policy statement, as drafted by the UAW-CIO Social Security Department, was read by Doctor Portteus. Following discussion, on motion of Drs. Mitchell and May, the Council adopted a resolution suggesting that Blue Shield endeavor to make adjustments in its policy in order to meet any conditions which might arise.

(4) *Proposed expansion of the Rural Health Committee's program.* Each member of the Council was given a four-page memorandum outlining the proposed program of the Committee on Rural Health, which the Executive Committee had approved in principle at its meeting on April 15, 1950. On motion of Drs. Elton Clarke and Olson, this proposed program was approved in principle by the Council.

(5) *Increase in salaries.* On motion of Drs. Howard and May, the Council voted to increase the salaries of the two JOURNAL office assistants, beginning May 1, 1950.

On motion of Drs. Elton Clarke and Olson, the salary of the field secretary is to be increased, beginning May 15, 1950, in accordance with the contract made with him at the time of his employment on May 15, 1949.

Unfinished Business

Indiana A.M.A. Campaign Coordinating Committee. Doctor Nafe, chairman, reported on the numerous activities of this committee, as follows:

1. *Resolutions.* As of April 15, 1950, 1,011 resolutions opposing compulsory health insurance have been secured from local, district, and state-wide organizations, which is 20 percent of the total of the nation.

2. *Advertising campaign.* Keeling & Company, of Indianapolis, selected to set up the newspaper advertising campaign in Indiana.

3. Importance of correlating program with those of the Legislative Committee and the Woman's Auxiliary.

4. Arranging for Dr. Ralph J. Gampell to speak in Indiana in May and June.

1950 (101st) Annual Session at French Lick

Tipping. Following the reading of letters from Dr. W. M. Cockrum, co-chairman of the Committee on Convention Arrangements, and several organizations whose conventions have operated under the prepaid gratuity system suggested by the management of the French Lick hotel, on motion of Drs. May and Garner, the Council voted that tipping be done by the individual at the French Lick Springs Hotel.

Membership Problems

Waiver of payment of state dues. Doctor Mitchell explained that at the present time there is no provision in the Constitution and By-Laws which permits the remission of dues of physicians who are incapacitated and who, because they are not yet 75 years of age, cannot qualify for senior membership in the association. The American Medical Association has ruled that a doctor's A.M.A. dues can be remitted providing the county and state societies remit his dues. In order to give these men the benefit of county, state and A.M.A. membership, Doctor Mitchell offered the following amendment to Chapter XI, Section 12, of the By-Laws, for presentation to the House of Delegates in September:

"In the event the county society remits a member's dues for good cause and the secretary of a county medical society recommends in writing the remission of the state dues of a member of the society, and shows good cause why such recommendation should be granted, the Council shall have the power to remit said dues."

On motion of Drs. Elton Clarke and Catlett, this amendment was approved by the Council.

Legislative Matters

Doctor Wright, co-chairman of the Legislative Committee, discussed the work and problems of his committee.

On motion of Drs. May and Mitchell, the Council went on record as opposed to any change in the Medical Practice Act.

On motion of Drs. Howard, Mitchell and Clauser, the Council reaffirmed its approval of the Legislative Committee and instructed this committee to follow the A.M.A.'s policies insofar as legislative activities are concerned.

Organization Matters

Grievance Committee. Letter received by the president of the association from the Floyd County Medical Society containing a motion passed by that society "expressing the disapproval of the executive action in establishing the Grievance Committee" was read by the executive secretary. Doctor Black then read a letter written by the attorney for the association in which he said: "You certainly have not exceeded your authority in appointing the subcommittee, and in our opinion, have carried out the intent and recommendation contained in the committee report." On motion of Drs. Garner and May, the Council is to send a copy of the letter written by the association's attorney to the Floyd County Medical Society.

New Business

(1) *Report of Committee to Study Training of Girls to Do Simple Laboratory Procedures.* Doctor Booher, chairman, reported that two meetings of this committee had been held, the minutes of which follow:

MINUTES OF FIRST MEETING OF COMMITTEE TO STUDY TRAINING OF GIRLS TO DO SIMPLE LABORATORY PROCEDURES

December 11, 1949

The Committee created by the House of Delegates of the Indiana State Medical Association to study the feasibility of offering a course in simple laboratory procedures for girls who work in doctors' offices, met on the request of C. S. Black, M.D., president of the Indiana State Medical Association, at 11:00 A.M., December 11, 1949, in the Circle Room at the Columbia Club in Indianapolis for the purpose of organization and preliminary discussion of the problem under consideration.

Members of the committee present at the meeting were: Norman R. Booher, M.D., temporary chairman, W. D. Close, M.D., Paul Fouts, M.D., Lall G. Montgomery, M.D., Clyde G. Culbertson, M.D., and Claude D. Holmes, Sr., M.D. Maurice V. Kahler, M.D., was absent, and his place was taken by Lester D. Bibler, M.D., representing the Indiana Academy of General Practice. Donald Wolfram, M.D., was absent.

C. S. Black, M.D., president, Indiana State Medical Association, and Ray E. Smith, Executive Secretary of the Indiana State Medical Association were also present.

Norman R. Booher, M.D., was elected chairman and Lall G. Montgomery, M.D., was elected secretary of the Committee.

General discussion of the problem under consideration followed.

After considerable discussion of the need for qualified medical laboratory workers for physicians' offices and methods of filling this need, the following general principles were agreed upon by the entire committee:

1. We, the Committee to Study Training of Girls to Do Simple Laboratory Procedures, recommend to the State Medical Association that the Indiana Legislature be urged to make the necessary appropriations of funds for the use of the Indiana University in extending its facilities for the training of larger numbers of fully qualified medical technologists.

2. This committee believes and recommends that qualified medical laboratory workers should be available for physicians' offices.

3. The committee recommends that since there are several official organizations which have long been en-

gaged in the training of medical laboratory workers, the subject of expanding the facilities for such training be further explored, and that some mutually agreeable means may be proposed which will best serve the interests of all, and which will fulfill the need for larger numbers of trained medical laboratory workers for physicians' offices.

Having agreed upon these recommendations, it was decided to hold a further meeting on January 29 for further discussion of the problem. The meeting adjourned at 2:00 P.M.

Lall G. Montgomery, M.D.,
Secretary of Committee

MINUTES OF SECOND MEETING OF COMMITTEE TO STUDY TRAINING OF GIRLS TO DO SIMPLE LABORATORY PROCEDURES

The final meeting of the committee created by the House of Delegates of the Indiana State Medical Association at its meeting in September, 1949, for the purpose of studying the training of girls to do simple laboratory tests in doctors' offices, was held on Sunday, January 29, in Parlor "T" of the Claypool Hotel, Indianapolis.

The meeting was called to order by the chairman, Norman R. Booher, M.D. Those present who were members of the committee were:

Norman R. Booher, M.D., Indianapolis
Maurice V. Kahler, M.D., Indianapolis
W. D. Close, M.D., Indianapolis
Paul Fouts, M.D., Indianapolis
Lall G. Montgomery, M.D., Muncie
Clyde G. Culbertson, M.D., Indianapolis
Claude D. Holmes, M.D., Frankfort
(Absent) Don G. Wolfram, M.D., Indianapolis

and also present were:

John D. Van Nuys, M.D., Dean, Indiana University School of Medicine
J. L. Arbogast, M.D., Director, Clinical Laboratory, Indiana University School of Medicine
Lester D. Bibler, M.D., Indianapolis, Indiana Academy of General Practice

The minutes and report of the previous meeting were accepted as mailed by the secretary, Lall G. Montgomery, M.D.

Further discussion of the problems under consideration were continued and further recommendations were formulated as follows:

1. It was moved by C. G. Culbertson, M.D., and seconded by W. D. Close, M.D., and passed by a unanimous vote that—
   We, the Committee to Study Training of Girls to do Simple Laboratory Procedures, recommend that the Indiana State Medical Association urge the Indiana Legislature, at its next session, to take the necessary steps to make funds available to increase all the requisite facilities for the training of fully qualified medical laboratory workers in Indiana University.
2. It was moved by M. V. Kahler, M.D., and seconded by C. D. Holmes, M.D., and passed unanimously, that—
   The Indiana State Medical Association formulate some coordinated plan to facilitate the recruitment and placement of prospective student medical laboratory workers in approved training schools, and that suitable publicity be directed to pathologists and hospitals throughout the state urging the establishment of more approved schools for the training of medical laboratory workers.
3. It was moved by C. G. Culbertson, M.D., and seconded by C. D. Holmes, M.D., and passed unanimously, that—
   the Council on Medical Education and Hospitals of the American Medical Association be requested to urge all interested organizations and agencies to increase the facilities for training qualified medical laboratory workers to fill the great national needs, and that—
   the Council also be asked to call a conference of representatives of the following organizations and agencies;
   Registry of Medical Technologists,
   Board of Approved Schools of Medical Technology,
   American Society of Clinical Pathologists,
   College of American Pathologists,
   American Society of Medical Technologists,
   American Hospital Association,
   American Academy of General Practice,
   as well as any other organizations or agencies which might be interested or helpful, for the purpose of discussing problems and formulating plans, with the objective of increasing the training of qualified medical laboratory workers.
4. It was moved by M. V. Kahler, M.D., and seconded by C. D. Holmes, M.D., and passed by a unanimous vote that—
   in consideration of the very pressing need for laboratory workers, the Council on Medical Education and Hospitals of the American Medical Association be further requested to make adequate provision for immediately supplying laboratory workers for medical practitioners' offices, and that this be given the most urgent attention.
5. It was moved by L. G. Montgomery, M.D., and seconded by J. L. Arbogast, M.D., and passed unanimously that—
   the Executive Committee of the Indiana State Medical Association be asked to survey the present use of medical laboratory workers in physicians' offices.

It was agreed by consent that all these matters constitute a long-range program, and that such a program will require the energetic cooperation of all those interested in the problems involved.

It was further agreed by consent that these minutes together with the preliminary minutes be adopted as the final minutes of this committee and that this report be completed and mailed to all members of the committee and those attending the meetings of the committee as consultants.

There being no further business the meeting adjourned.

Lall G. Montgomery, M.D.,
Secretary

Doctor Booher read the following letter which he had written to Doctor Black on February 10, 1950:

"In your letter, under date of November 16, 1949, you directed that the 'Committee to Study Training of Girls to do Simple Laboratory Procedures' should hold its first meeting on December 11, 1949. This meeting was held and the undersigned was elected chairman and Dr. L. G. Montgomery of Muncie was elected secretary. A second meeting of this committee was held on January 29, 1950 and the detailed notes of the two meetings have been submitted to the executive secretary of the Indiana State Medical Association.

"The committee did a tremendous amount of work to try to determine if there was a need among doctors of the State of Indiana, as well as any other states, for the training of their office assistants in laboratory procedure. They contacted deans of medical schools and numerous laboratories and had the advice of a number of physicians specializing in this field. It was felt that a definite need was shown for the services of laboratory technicians or personnel with laboratory training in the office of doctors in this state. It was also our opinion that the available number of fully trained and accredited laboratory personnel is woefully inadequate for our needs. We further found that the training facilities for all kinds of laboratory personnel are woefully inadequate in this and other states. We found that there is no proper correlation between people desiring to take this

training and the training schools available. We found that pathologists were on the whole opposed to short term training on the basis that correct results could not be expected from a person trained in less than the courses outlined for such training by the various certifying and licensing authorities in this field. We found that general practitioners and to a lesser extent the internists felt that personnel could be trained for office assistants in less than the time prescribed at present. It is obvious that some type of plan must be approved at the highest level of medical authority before short term training of doctor's assistants can be officially approved. We found that Indiana University is the principal training school for laboratory technicians in Indiana and that it is tremendously handicapped for lack of funds, physical equipment and personnel to train technicians at the present time.

"Your study committee recommends that the State Association should urge the Indiana State legislature to make an appropriation of funds in its next session to correct the glaring deficiencies in laboratory training facilities available. Your committee further recommends that medical laboratory workers should be available for physicians' offices and that the organizations engaged in such training be urged to expand their facilities and find a mutually agreeable means by which the need for trained medical laboratory workers in physicians' offices can be met. It is recommended that we make a strong effort to increase the number of personnel trained in our training schools and that the State Association formulate a correlated plan to get people desiring this training in touch with training schools which may be able to give them such training.

It is further recommended that the A.M.A. Council on Medical Education and Hospitals be urged to call a conference of those organizations listed in the minutes of this committee and the other large representative groups of medical practice in the United States to discuss these problems and formulate definite, workable plans for their solution, and it is very strongly recommended that this Council be urged to set up some experimental plan for the training of office assistants until such time as there shall be available accredited laboratory technicians in sufficient supply for employment in doctors' offices who desire them.

Your committee feels that much constructive good can come from the adoption of this program by the Indiana State Medical Association but also knows that unless the Council takes prompt and vigorous action, nothing will be done. The minutes of the committee's meetings are enclosed."

Doctor Booher supplemented this letter with the following information:

1. The reason that this matter was referred to the state medical association is that the dean of Indiana University School of Medicine feels that before a plan for setting up such a training course can be presented to the Board of Trustees, it would have to be approved by the state medical association.
2. The Study Committee has established that this is a feasible, possible program, and one that the Indiana State Medical Association might well endorse. If such a program is endorsed, it is probable that certain of the pathologists would like to handle it in their approved laboratories, and this would be the most satisfactory plan in each community. If it is taken to the University, there is a good chance of getting it started there. The plan now has approval of the American Board of Pathology. Similar plans are in operation elsewhere.
3. The committee would like to have action from the Council at this time rather than wait until the French Lick meeting.

Following discussion by Drs. Portteus, Dodds and Booher, on motion of Drs. Catlett and Clarke this matter was deferred for further consideration at the next meeting of the Council.

The executive secretary was instructed to write Doctor Booher, expressing the Council's appreciation for the vast amount of work he and his committee had done, and telling him that the Council feels that it should give some more thought to the matter before taking final action.

(2) *Summer meeting of the Council.* On motion of Drs. Mitchell and Garner, the next meeting of the Council will be held on Sunday, July 16, 1950.

There being no further business, the meeting was adjourned.

EXECUTIVE COMMITTEE

April 15, 1950

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D.; W. U. Kennedy, M.D.; A. F. Weyerbacher, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Guest: R. S. Saylor, executive vice-president, Mutual Medical Insurance, Inc.

Membership Report

Number of members March 31, 1950	*3,325
Number of members March 31, 1949	3,478
Loss over last year	153
Number of members December 31, 1949	3,758

* Includes 19 in military service; 104 $10 members; 192 senior members.

1950 Annual Session, French Lick, September 25, 26 and 27, 1950

Banquet speaker. On recommendation of the president, Cecil M. (Stuttering Sam) Hunter, of Amarillo, Texas, was selected as the banquet speaker, on motion of Drs. Clark and Weyerbacher.

By consent, permission was given the Committee on Instructional Courses to publicize the names of the instructors who will give the instructional courses.

Indiana A.M.A. Campaign Coordinating Committee

The field secretary gave a report on the activities of the committee, pointing out that to date 1,011 resolutions had been adopted by Indiana organizations, which is 20 percent of the total in the nation. Upon motion of Drs. Ellison and Clark, it was voted to rent space at the 1950 Home Show for distribution of literature against socialized medicine.

Statements of receipts and expenditures for March for the association and THE JOURNAL were approved.

Legislative Matters

National

On motion of Drs. Clark and Kennedy, the suggestion from the Council of the Indianapolis

(Continued on page 508)

Extensive mucosal destruction and ulceration from chronic ulcerative colitis with only a few inflammatory polyps.

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ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE

(Continued from page 506)

Medical Society that the state medical association survey its members to see whether they are members of a veteran's organization and the post to which they belong, was rejected. It was deemed the duty of the county medical society to gather this information and make use of it.

Local

Upon motion of Drs. Clark and Weyerbacher, the committee agreed to pay up to $400 of the expenses of the physician-delegate from the Paul Coble Post to the 1950 National Legion Convention in Los Angeles in October. The commander and adjutant of the post are to be asked to appear before the Executive Committee on May 21 to outline plans for representing the interests of the medical profession at the convention.

Organization Matters

Indiana Public Health Association.

a. On motion of Drs. Clark and Ellison, Dr. Portteus was selected as the state medical association delegate to the meeting of the Indiana Public Health Association, April 17 and 18, in Indianapolis.

b. On motion of Drs. Ellison and Clark, renewal of the association's membership at $10 per year in the Indiana Public Health Association was approved.

UAW-CIO insurance coverage demand. Mr. Saylor reported the demand being made by the UAW-CIO in negotiating for a new contract, after which, on motion of Drs. Clark and Black, it was voted to recommend to Mutual Medical Insurance, Inc., that it develop a policy to meet the competition of increased coverage, at an increased premium, and if such a policy is developed by Mutual Medical Insurance, Inc., that it be submitted to the component county medical societies of the state medical association for ratification.

Request of city health commissioner of Goshen. On motion of Drs. Clark and Weyerbacher, answer to the question presented by the city health commissioner of Goshen regarding optometrists participating in the annual preschool round-up examinations was left to the Elkhart County Medical Society.

Request for credit on 1950 membership dues. Letter received from a Hammond physician, stating he was entering a residency at the Mayo Clinic, beginning April 1, 1950, and asking that his 1950 state dues be set aside and he be given credit for the $35.00 when he completes his residency and returns to Indiana, was read. In the event the doctor may become a member of the Minnesota State Medical Association by transfer, it was taken by consent that his request be disallowed.

Multiphasic screening program. A letter from the director of the Bureau of Local Health Administration, Indiana State Board of Health, asking for the association's approval of the multiphasic screening program was read. On motion of Drs. Clark and Black, the headquarters office was directed to procure the American Medical Association's attitude on this type of clinic and present it to the committee at its meeting on May 21.

Letter from the chairman of the Committee on Education of the American Academy of General Practice, asking the association to become a member of the Associated State Post Graduate Committee at an annual membership fee of $25.00, was read. The executive secretary was asked to get more information about the organization and present the matter to the May 21 meeting of the committee.

Proposed expansion of Rural Health Committee's program. On motion of Drs. Clark and Kennedy, the committee approved in principle the program as outlined by the Committee on Rural Health.

Audiometer testing in public schools. A recommendation of an Indianapolis school physician that a bill be sponsored in the next session of the Indiana General Assembly changing the present law concerning audiometer testing of school children was referred to the Committee on Public Policy and Legislation, on motion of Drs. Kennedy and Ellison.

The Journal

Revision of mailing list. On motion of Drs. Clark and Ellison, THE JOURNAL was directed to remove the names of unpaid members from the mailing list after mailing of the March issue each year.

University Microfilms. Request of University Microfilms, Ann Arbor, Michigan, for the exclusive privilege of reproducing copies of THE JOURNAL in reduced form was tabled, on motion of Drs. Clark and Ellison.

There being no further business, the Executive Committee adjourned to meet again at 10:00 a. m. Sunday, May 21, 1950, at the Columbia Club.

COMMITTEE ON PUBLICITY

April 7, 1950

Present: Marlow W. Manion, M.D., chairman; James O. Ritchey, M.D.; Homer G. Hamer, M.D., Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary; and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of May 1, 1950—"Care of Feet."
Week of May 8, 1950—"Hard of Hearing."
Week of May 15, 1950—"Poison Ivy."
Week of May 22, 1950—"Swimming Safety."

The secretary read a letter from America's Future, Inc., of New York City, offering the radio platters, "Americans, Speak Up!" at a special price of $2.00 per broadcast. He reported on information about this organization received from Dr. W. W. Bauer of the A.M.A. office. The committee postponed action pending further investigation.

The field secretary announced that Whitaker and Baxter were going to have spot announcement platters ready within a few weeks. He reported, too, that the Lake County Medical Society was starting a radio series entitled, "Drama, M.D."

(Continued on page 510)

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ACCEPTED FOR ADVERTISING BY THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

(Continued from page 508)

The committee instructed the field secretary to procure motion picture films believed suitable for television programs for review at the next meeting.

COMMITTEE ON PUBLICITY

April 21, 1950

Present: Marlow W. Manion, M.D., chairman; Homer G. Hamer, M.D.; and James A. Waggener, field secretary. Arthur P. Tiernan, executive secretary of the Vanderburgh County Medical Society was a guest.

The following "Hints on Health" columns were approved.

Week of May 29, 1950—"Tuberculosis."

Week of June 5, 1950—"Appendicitis."

The secretary read a letter from George Lull, M.D., general manager of the A.M.A., and one from W. W. Bauer, M.D., chairman of the health education division of the A.M.A. Both letters were in response to inquiry made about the radio series, "Americans, Speak Up!" Following the discussion of the correspondence, the committee instructed the secretary to write a letter to the A.M.A., requesting a positive statement of policy regarding this program, and inquire if the A.M.A. proposed, either itself or through its National Education Campaign Office, to prepare similar radio materials for use by the county societies.

The committee previewed the films "The Doctor" and "Journey Into Medicine" for possible use on television. Approval was given for the use of the latter film.

COUNCILOR DISTRICT MEETING

First District

Dr. Herman T. Combs of Evansville was re-elected councilor for the First District at the annual district meeting held in Evansville May 9 in connection with a meeting of the Vanderburgh County Medical Society. Dr. Paul D. Crimm of Evansville was re-elected alternate councilor.

District officers elected were: Dr. W. O. Denzer, Evansville, president; Dr. William Challman, Mount Vernon, vice-president, and Dr. Victor Huggins, Evansville, secretary-treasurer.

Dr. George Garceau of Indianapolis delivered a paper on "Orthopedic Problems of the Shoulders and Feet." Ninety-three were present at the meeting.

Seventh District

Dr. J. William Wright received the unanimous endorsement of the Seventh District Medical Society for the office of president of the Indiana State Medical Association at the district group's spring meeting, May 9, in Indianapolis.

A resolution presented to the District Society called attention to Doctor Wright's long and capable service with the state association in committee work, and noted his especial interest in matters affecting public policy and legislation. It also called attention to his past presidency of the Indianapolis Society, the largest component county organization of the Association. It called on the delegates of the four societies comprising the district to work for his election at the annual convention next September in French Lick.

At the same meeting Dr. Roy A. Geider was chosen district councilor to succeed Dr. C. J. Clark who resigned recently. Doctor Geider will serve for the unexpired portion of Doctor Clark's term of office, i.e., until December 31, 1950. This means that an election will be held at the fall meeting of the district to name a councilor for the full three-year term.

Dr. Malcolm Scamahorn, district president, presided at the May 9 session. The scientific portion of the program featured Dr. Paul O'Leary, of the Mayo Clinic, who gave an illustrated lecture on "Nodular and Ulcerative Lesions of the Lower Extremities." He was presented as the third annual lecturer of the Brayton Foundation.

LOCAL SOCIETY REPORTS

LOCAL SOCIETY OFFICERS

LA GRANGE COUNTY MEDICAL SOCIETY
President, H. F. Flannigan, La Grange,
Vice-President, W. O. Hildebrand, Topeka,
Secretary-Treasurer, Alfred A. Wade, Howe.

STEUBEN COUNTY MEDICAL SOCIETY
President, Robert F. Barton, Angola,
Vice-President, James A. Alford, Hamilton,
Secretary-Treasurer, Norman W. Rausch, Angola.

WELLS COUNTY MEDICAL SOCIETY
President, Allen C. Nickel, Bluffton,
Vice-President, T. O. Dorrance, Bluffton,
Secretary-Treasurer, H. B. Annis, Bluffton.

Adams County Medical Society members held a meeting at the Adams County Memorial Hospital, in Decatur, on April 11. Dr. R. M. Lohman, of Fort Wayne, discussed the Red Cross Blood Bank program. Thirteen members were present.

Clay County Medical Society members held their regular meeting at the Elks Home in Brazil on April 11. Nine members were present.

Clinton County Medical Society members met at the Clinton County Hospital, in Frankfort, on April 4. Plans for a proposed addition to the hospital were discussed. Fifteen members and one guest were present.

Fayette-Franklin Counties Medical Society members met at the Country Club in Connersville on April 11. Dr. George M. Brother, of Indianapolis, spoke on "Modern Aspects of the Treatment of Venereal Disease, and the Management of Public Health Problems Locally." Thirteen members were present.

(Continued on page 512)

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(Continued from page 510)

Fountain-Warren Counties Medical Society held a meeting in Kingman on April 6. Twenty-eight members were present to hear Dr. Harlan A. English, of Danville, Illinois, speak on "Hematosis."

Greene County Medical Society members met at the Freeman Greene County Hospital, in Linton, on April 13. The twelve members present discussed a welfare program in Greene County.

Johnson County Medical Society members held a meeting in the Johnson County Memorial Hospital, in Franklin, on April 12. The guest speaker was Dr. Bennett Kraft, of Indianapolis, who spoke on "Allergy in General Practice." Seventeen members were present.

Madison County Medical Society members met at the Anderson Country Club in Anderson on April 17. Guest speakers were Dr. Frank M. Gastineau and Dr. James H. Gosman, both of Indianapolis, whose subject was "Common Skin Diseases." Forty-two members were present.

Owen-Monroe County Medical Society members met on April 27 at the Bloomington Country Club. A sound film on the technique of cancer detection was presented by Dr. Wendell Anderson, of Indianapolis. Dr. David Adler, of Columbus, spoke on "The Papanicolaou Technique of Cancer Cell Detection."

St. Joseph County Medical Society members met at the Indiana Club in South Bend on April 11. The guest speaker was Mr. John A. Scott, personnel director of the South Bend Tribune, who spoke on "Public Relations."

Vanderburgh County Medical Society members met at the Hotel McCurdy in Evansville, on May 9, when Dr. George J. Garceau, of Indianapolis, was the guest speaker. His subject was "Cervical Spine Syndrome."

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. D. E. Lybrook, Galveston.

President-elect—Mrs. F. M. Fargher, Michigan City.

Corresponding Secretary—Mrs. E. W. Bailey, Logansport.

Recording Secretary—Mrs. H. P. Sloan, New Albany.

Treasurer—Mrs. Robert Bolin, Elkhart.

Publicity—Mrs. F. M. Gastineau, Indianapolis.

All previous records were shattered during the sixth annual business meeting of the House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association, held in Elkhart April 27 and 28. Attendance and organization effort now places the Indiana Auxiliary among the top of all the states. An impressive program was enjoyed by the 165 delegates in attendance, and the new officers for the coming year pledged still greater achievements during their term of office. The 1951 session will be held at Terre Haute during the month of April.

The largest delegation of Auxiliary members in the history of the state organization attended the two-day session in the Elkhart Hotel. The sessions of the House of Delegates opened Thursday afternoon with an official board meeting to close the business of the Auxiliary for the year. Claude S. Black, M.D., President of the Indiana State Medical Association, spoke briefly at the meeting, praising the women for the outstanding accomplishments they had achieved in the educational campaign of the state association. The field secretary presented to the board three recommendations of the association. The executive committee had recommended that the Auxiliary appoint an Indiana A.M.A. Campaign Coordinating Committee to assist that committee of the association. It was also recommended that the mailing list of Auxiliary members be moved to the headquarters office in order to facilitate the distribution of materials from the state office. The final recommendation made called for a study of the advisability of the Auxiliary changing its constitution and by-laws to conform more nearly to those of the state association. Reports of the officers closed the afternoon meeting.

Thursday evening was devoted entirely to the educational and legislative campaigns of the association. Those in attendance were high in their praise of the evening meeting for the information it imparted to the representatives.

Following the invocation, addresses of welcome were given by Mrs. George Bowdin, President of the Elkhart Auxiliary, The Honorable Walter L. Larson, Mayor of the City of Elkhart, and Arthur W. Kistner, M.D., President, Elkhart County Medical Society. The response to the welcome was given by Mrs. Truman E. Caylor, retiring president of the state Auxiliary.

A musical interlude was given by members of the Elkhart City school system and proved enjoyable.

Mrs. Robert S. Bolin, of Elkhart, general chairman of the meeting of the House of Delegates, reviewed the program for the meeting and gave a summary of the general convention theme. Acknowledgment was made to the many Elkhart business firms and organizations who had cooperated in making the convention a success.

Mrs. Caylor, in delivering her president's address, stated that the accomplishments of the Auxiliary during the past year had been many, but much remained to be done. She pointed out that with conditions as they are, it was felt that the program that had been arranged for the evening meeting was of much more importance than their usual social program. "Organization of additional counties during the year has now brought the membership of the Auxiliary to a new high, but we must not be satisfied until we have met the request of the medical association, and completely organized every county in our state." She expressed her appreciation for the splendid spirit of cooperation experienced during her administration from all the officers and committee chairmen, and appealed for the same spirit to be accorded to the new officers for the coming year.

Claude S. Black, M.D., President of the Indiana State Medical Association, expressed the official greetings of the association and expressed appreciation for the fine program now being carried on by the Auxiliary.

Mr. James A. Waggener, field secretary of the association, gave a report on the educational campaign. Tracing the organization and program of the campaign, Mr. Waggener stated that with the cooperation of the Auxiliary, the results of the Indiana resolution campaign were outstanding in the nation. Indiana has passed the 1,200 mark, he stated, giving Indiana approximately 20 percent of the total resolutions in the nation. He asked for an intensified effort during the coming year, outlining the plans of the committee for the 1950-51 program.

Alfred Ellison, M.D., president-elect of the association, gave a challenging address, in which he pointed out

(Continued on page 514)

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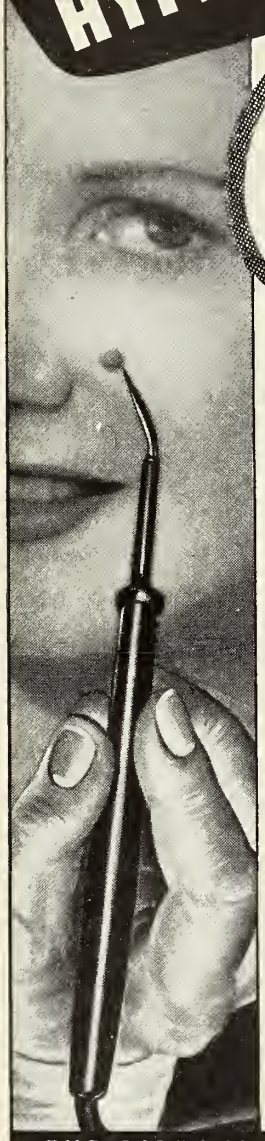

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(Continued from page 512)

that the medical profession is under attack from all sides. "We have made many of our enemies wary, and have made them retreat from their positions, but now a sniping campaign is being carried on, and we are the targets. We cannot afford to relax for one moment in our efforts to defeat those who would socialize our profession and the people of this country; we must remain alert; we must practice good medicine, give the people good service, and remain on the offensive in our battle to keep our nation a nation of free, unregimented individuals and professions."

Ernest B. Howard, M.D., assistant general manager of the American Medical Association, told of the national program, the problems confronting the profession at the national level, and the steps that were being taken to combat those who would socialize the medical profession. He praised the work of the Indiana State Medical Association and its Auxiliary in the educational campaign, acknowledging the appreciation of the American Medical Association for the leadership the state had assumed in this program.

The Friday program began with a memorial breakfast, honoring those whose faithful service and devotion had been lost by the Auxiliary during the year. The program was in charge of Mrs. H. T. Goodman of Terre Haute.

The opening session of the House of Delegates was given over to reports of the officers, committee chairmen and county Auxiliary presidents. Presidents of the new county Auxiliaries organized during the year were introduced.

During the luncheon session, Mrs. Kris Peterson of the Public Relations Department of the American Medical Association spoke on the many activities of the A.M.A. Her remarks took those in the audience on a tour of the headquarters building in Chicago and an explanation of the responsibilities of each of the departments.

Mrs. Paul C. Craig, of Reading, Pennsylvania, Public Relations Chairman of the Woman's Auxiliary to the American Medical Association, spoke of the work the Auxiliaries could do in helping the medical association in the many programs they are carrying on. She, too, expressed praise for the program being carried on by the Indiana Auxiliary. "We, too, must intensify our efforts to help our husbands. There are many things we can do to help, and many burdens we can shoulder for our husbands, especially the details of the educational campaign they are now conducting. You in Indiana have certainly done much of this already, but I know that you are prepared to do much more. We of the national organization are watching, with interest, your program, and we will continue to watch in the future. Our work lies in an overall public relations program and we must not hesitate to do anything and everything our husbands and their societies request of us and approve for us to do in these fields."

The report of the nominating committee was accepted and the following were installed in an impressive ceremony to carry on the work of the Auxiliary during the coming year: President, Mrs. D. E. Lybrook, Galveston; President-elect, Mrs. F. M. Fargher, Michigan City; Recording Secretary, Mrs. H. P. Sloan, New Albany; Corresponding Secretary, Mrs. E. W. Bailey, Logansport; Treasurer, Mrs. Robert Bolin, Elkhart.

Vice-presidents were installed as follows: first, Mrs. H. T. Goodman, Terre Haute; second, Mrs. W. B. Matthew, Indianapolis; third, Mrs. Eugene Austin, Evansville; fourth, Mrs. C. H. Proudfit, South Bend.

Mrs. Truman E. Caylor, Bluffton, was installed as Councilor.

Mrs. D. E. Lybrook, of Galveston, upon assuming the office of President of the Auxiliary, named the following committee chairmen: Legislation, Mrs. G. W. Wagoner,

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(Continued from page 514)

Delphi; Public Relations, Mrs. S. J. Petronella, East Chicago; Bulletin, Mrs. M. B. Gevirtz, Hammond; Program, Mrs. C. L. Richardson, Rochester; Parliamentarian, Mrs. C. F. Voyles, Indianapolis; Historian, Mrs. F. S. Cuthbert, Kokomo; Archives, Mrs. C. G. Smith, Otterbein; Publicity, Mrs. F. M. Gastineau, Indianapolis.

Other committee chairmen named are as follows: *Today's Health,* Mrs. M. F. Grieber, Muncie; Radio, Mrs. W. R. Morrison, Kokomo; Educational A.M.A. Campaign Coordinating Committee, Mrs. Truman E. Caylor, Bluffton; Editor of *The Hoosier Doctor's Wife,* Mrs. A. W. Ratcliffe, Evansville.

The meeting of the House of Delegates was adjourned to meet again during the convention of the Indiana State Medical Association, this fall at French Lick, to approve the changes recommended in the constitution and by-laws.

As the delegates started for their homes, they were tired but happy in the knowledge that their efforts were appreciated, and determined in their minds to work toward greater accomplishments in the months to come.

INDIANA STATE BOARD OF HEALTH
Division of Communicable Disease Control

MONTHLY REPORT—MARCH, 1950

Disease	Mar. 1950	Feb. 1950	Jan. 1950	Mar. 1949	Mar. 1948
Brucellosis	2	0	1	3	7
Chickenpox	283	363	341	561	668
Conjunctivitis	12	1	0	13	2
Diphtheria	16	24	26	32	37
Encephalitis	1	2	2	2	7
Erysipelas	1	3	0	1	2
Food infection	3	0	1	0	0
Influenza	113	37	53	40	42
Infectious hepatitis	5	17	0	0	0
Measles	1112	676	211	572	3454
Meningitis,					
Unclassified	6	8	5	3	6
Influenza	1	0	2	2	2
Meningococcus	3	1	6	2	1
Pneumococcus	1	0	0	1	0
Diplococcus	1	0	0	0	0
Purulent	1	0	0	0	0
Mumps	195	161	183	184	811
Paratyphoid fever	1	0	1	1	0
Pneumonia	71	32	51	60	43
Poliomyelitis	4	2	11	3	4
Rabies in animals	30	55	29	75	73
Rheumatic fever	1	0	2	1	0
Rubella	79	52	23	85	25
Scarlet fever	326	210	192	394	298
Tetanus	1	0	0	0	0
Tuberculosis,					
Pulmonary	175	170	221	171	136
Other forms	17	14	7	19	4
Tularemia	1	2	1	4	1
Typhoid fever	2	3	6	5	1
Vincent's angina	1	1	1	0	0
Whooping cough	151	157	100	73	121

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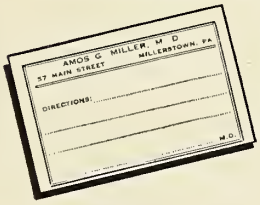

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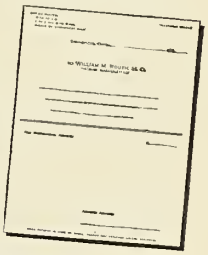

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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

MEDICAL MANAGEMENT OF GASTROINTESTINAL DISORDERS. By Garnett Cheney, M.D., clinical professor of medicine, Stanford University Medical School. 478 pages, with 29 figures. Price, $6.75. Year Book Publishers, Inc., Chicago, 1950.

MEDICINE OF THE YEAR, 1950. Editorial Direction, John B. Youmans, M.D., dean, School of Medicine, Vanderbilt University. 204 pages. Price, $5.00. J. B. Lippincott Company, Philadelphia, 1950.

THE QUALITY OF MEDICAL CARE IN A NATIONAL HEALTH PROGRAM. By the Sub-committee on Medical Care of the American Public Health Association. Reprinted from the American Journal of Public Health, Vol. 39, No. 7, July 1949. 32 pages. Price, 10 cents. American Public Health Association, New York, 1950.

A MANUAL OF CARDIOLOGY. By Thomas J. Dry, M.A., M.B., Ch.B., M.S. in Medicine, Associate Professor of Medicine, University of Minnesota (Mayo Foundation); Consultant in Section on Cardiology, Mayo Clinic. 2nd Edition. 355 pages with 97 figures. Price $5.00. W. B. Saunders Company, Philadelphia, 1950.

SEXUAL DEVIATIONS. By Louis S. London, M.D., diplomate American Board of Psychiatry and Neurology; Frank S. Caprio, M.D., member American Psychiatric Association; with a foreword by Nolan D. C. Lewis, M.D., professor of psychiatry, College of Physicians and Surgeons, Columbia University, director New York State Psychiatric Institute and Hospital, editor. The Psychoanalytic Review. 702 pages. Price, $10.00. The Linacre Press, Inc., Washington, D. C., 1950.

COAGULATION, THROMBOSIS, and DICUMAROL. With an appendix on related laboratory procedures. By Shepard Shapiro, M.D., assistant professor of clinical medicine, New York University College of Medicine; visiting physician, Third (New York University) Medical Division, Goldwater Memorial Hospital; associate physician, Lincoln Hospital; and Murray Weiner, M.D., fellow in medicine, New York University College of Medicine; research assistant, Third (New York University) Medical Division, Goldwater Memorial Hospital; assistant visiting physician, Willard Parker Hospital Chest Service; clinical assistant visiting physician, Bellevue Hospital. 131 pages. Price, $5.50. Brooklyn Medical Press, New York City, 1949.

MEDICAL GYNECOLOGY. By James C. Janney, M.D., Associate Professor of Gynecology, Boston University School of Medicine; Associate Visiting Gynecologist, Massachusetts Memorial Hospital. 2nd edition. 454 pages with 108 figures. Price $6.50. W. B. Saunders Company, Philadelphia, 1950.

HANDBOOK OF OBSTETRICS AND DIAGNOSTIC GYNECOLOGY. By Leo Doyle, M.D., Berkeley, California. 240 pages, with 45 figures. Price $2.00. University Medical Publishers, Palo Alto, California, 1950.

SAW-GE-MAH (Medicine Man). By Louis J. Gariepy, M.D., Detroit, Michigan. 326 pages. Price $3.00. Northland Press, St. Paul, Minnesota, 1950.

HARVEY CUSHING: Surgeon, Author, Artist. By Elizabeth H. Thomson, research assistant at the Historical Library of Yale University School of Medicine. 347 pages, with 13 illustrations and 12 plates. Price $4.00. Henry Schuman, Inc., New York City, 1950.

YOU AND YOUR HEART. By H. M. Marvin, M.D., president, American Heart Association, associate clinical professor of medicine, Yale University; Irving S. Wright, M.D., president, New York Heart Association, professor of clinical medicine, Cornell University; Irvine H. Page, M.D., director of research, Cleveland Clinic Foundation, chairman Medical Advisory Board Council for High Blood Pressure Research of the American Heart Association; T. Duckett Jones, M.D., medical director of the Helen Hay Whitney Foundation; David D. Rutstein, M.D., professor of preventive medicine, Harvard University. 306 pages. Price $3.00. Random House, New York City, 1950.

PROCTOLOGY IN GENERAL PRACTICE. By J. Peerman Nesselrod, M.D., associate in surgery, Northwestern University Medical School. 276 pages with 64 figures. Price $6.00. W. B. Saunders Company, Philadelphia, 1950.

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VOLUME 43 JULY, 1950 NUMBER 7

ARTIFICIAL INSEMINATION

THE public interest in this subject may be more intense than the importance of the subject deserves—particularly during this scientific age when the tendency is to establish the importance or nonimportance of anything by statistics. The number of children as the result of artificial insemination must be very small. The percentage of the population that could have any interest, other than purely academic or only of curiosity, surely could not be more than an infinitesimal fraction of a percent.

No attempt will be made in this article to deal with the question as a moral, spiritual or sociological question, whatever its implications may be in those fields. Those who labor to serve mankind in those fields can be neither enlightened nor disturbed by this article, for it will deal only with the legal aspects of the subject.

There is no crime known to the courts of the United States which is not defined in the Criminal Code. In an earlier day there were some recognized common law crimes—that is, crimes which were declared to be such by the courts. But all such crimes have been abolished by acts of the Legislatures, and no conduct can subject one to a criminal penalty, or even a criminal prosecution, in America if his conduct does not violate the word of some act of a Legislature.

Artificial insemination has not reached the point where the Legislatures have given active attention to it. It is possible, however, that there could be involved in the technique of artificial insemination the commission of a crime. In artificial insemination, just as in natural insemination, there must be the bringing of the spermatozoa of the male into a place where fertilization of an ovum may take place under such conditions that the embryo resulting therefrom may make an attachment to the uterus in such a manner that it may develop into an offspring sufficiently mature at delivery to maintain its existence separate and distinct from the mother. Exactly when conception takes place is not of much significance in this discussion. It may be assumed, however, that the union of a spermatozoa with an ovum constitutes fertilization as distinguished from conception which may be regarded as occurring when the attachment of the fertilized ovum is made to the uterus—for prior to that time it would seem that no significant change begins in the female through which she becomes the source of nourishment and possibility for growth and development to the fetus.

Therefore, if the sperm is introduced to contact or to the point from which it itself makes contact with and fertilizes an ovum, by some technique which does not involve any sex crime as defined in the law, there could be no crime in artificial insemination. The problem then, so far as the medical one concerning conception is concerned, is the problem of obtaining the sperm in a noncriminal manner and depositing it in a noncriminal manner. It may be obtained without surgical procedure, either through masturbation or copulation. There is a statute in Indiana regarding masturbation, but the language of that statute would not make it applicable to a situation where the male performed the act on himself. The pertinent part of that statute on the subject reads as follows:

> "Whoever entices, allures, instigates or aids any person under the age of twenty-one (21) years to commit masturbation or self-pollution shall be deemed guilty of sodomy, and, on conviction, shall be fined not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000), to which may be added imprisonment in the state prison not less than two (2) years nor more than fourteen (14) years." (Burns Indiana Statutes, 1942 Replacement, Section 10-4221.)

But if the man, without enticement, allurement, instigation or aid, performs masturbation on himself, no crime is committed.

If the sperm is obtained through a sex act, where the parties who engage in the act are a married

couple, no sex offense is committed. However sperm is obtained, once the physician has it in his control and then by artificial means deposits it within the mother, there is no sexual act involving the mother. Thus she may conceive without any act that falls within the condemnation of the law, and the sperm may also be obtained without any crime.

The technique followed might be that after the sex act between a married couple occurs, the sperm might then be taken up by artificial means and administered to another woman.

As a matter of legal interest in connection with this problem of those married couples who have been unable to have children, attention might appropriately be called to the fact that no act of adultery or fornication, as defined under the law, need be involved where artificial insemination is performed. It is possible that artificial means are resorted to because of conscientious consideration for obedience to the law. The crimes of adultery and fornication in the state of Indiana are defined as follows:

> "Whoever cohabits with another in a state of adultery or fornication shall be fined not exceeding five hundred dollars ($500.00), or imprisoned in the county jail not exceeding six (6) months, or both." (Burns Indiana Statutes, 1942 Replacement, Section 10-4207.)

It will be noted that the definition of these crimes does not cover occasional acts of adultery or fornication. The commission of the sex act between a man and woman who are not married to each other, where either or both are married at the time, is adultery; where neither is married at the time, it is fornication.

The Supreme Court of Indiana has held that the words "to cohabit in a state of adultery or fornication" means a living together of the parties "in the manner of husband and wife." But there are sociological and psychological objections to such occasional acts even though no crime is committed. Where such acts occur with the consent of the spouses of the parties engaged in the occasional acts, there is no ground for divorce because of them. But the dangers that lurk in the psychological and sociological situations should themselves be strong enough to condemn utterly the plan of obtaining children through natural but extramarital methods. That method may be so offensive to the sense of honor and the sentiments expressed in the marriage vows that the psychological consequences in the form of guilt complexes, which may never be forgotten, would cause much grief and pain. It would seem that resort to artificial means would, for many people, avoid what might be unhappy sequelae.

The next situation that presents itself is the status of the child as to his legal relationship to the person who produces the sperm if that person is not his mother's husband. Under these circumstances, who is the legal father? If biological succession is to determine, then of course the man who furnished the sperm is the father, and the child would be classed as an illegitimate child, if that man is not the husband of the mother. But the law in its eagerness to protect the rights of children disregards science in determining paternity, in many instances. The law will presume that a child born in wedlock, no matter how he was conceived, is a legitimate child. This presumption can be overcome only by the most persuasive evidence.

To show how strong this presumption of legitimacy is and to what extent it will be indulged—a case reported in England, whose common law was adopted in this country, except in Louisiana, was decided many years ago in favor of the legitimacy of a child born under the following circumstances: The father went to sea as a member of the crew of a sailship, which did not return to England for seven years; the father continued a member of the crew during that entire period; when the ship returned the sailor found that his wife had given birth to a child about four years after he had sailed from England; shortly after this sailor returned to his home he died and left a small estate; then the question was whether the child was legitimate and therefore entitled to inherit a part of the estate. The English judge decided that the child was legitimate. In explaining his decision the judge spoke of the power and force of the presumption of legitimacy, and he said in that connection that maybe the sailor had somehow visited his wife during the night-time when no one saw him come or leave.

This case is not cited as a precedent which would be certain to be followed in the United States.

But even if the medical technique of artificial insemination had been performed and during the time that this was done the husband and wife lived together, as the courts say "in the manner of husband and wife," it might be impossible to prove scientifically, at least in some instances, that the artificial insemination with sperm of a man other than the husband had produced the conception. Not infrequently a husband and wife live together for several years before their desire for children is gratified; and then when a child does come it comes without artificial insemination and with complete certainty that the husband is the father.

So it would seem as a practical matter that the child of any artificial insemination of a married woman would be legally regarded as the child of her husband, and that situations where the result would be otherwise would be rather difficult to imagine. It would appear practically impossible to obtain a legal decision that such a child would be illegitimate, no matter who as a biological fact was the father. The legal presumption in favor of the legitimacy of the child would prevail over the biological fact.

Of course, if this artificial insemination was done without the consent of the husband and by the use of the sperm of another man, it seems that the legal result would be otherwise. But it would appear that the husband who was not the biological father would not be permitted to deny any of the responsi-

bilities and obligations of a father to the child artificially conceived by use of the sperm of another man, if the husband gave his consent. This situation makes the consent of the husband important. Therefore, there are strong reasons for having the consent in writing. On the other hand, there may be reasons why all the parties would want no record made of the event, and thus prevent curious eyes from ever seeing a record that might prove embarrassing to anyone.

Artificial insemination of the mother without her consent should never be undertaken. To administer artificial insemination without her consent would not be rape but it would be assault and battery, for which she would have a cause of action against those who performed the act.

A DOCTOR MAKES A WILL

A DOCTOR finally comes to the place where he has a little time to consider what he has accumulated and how he can make it the most useful to his dependents as well as to himself. Then he begins to think of making a will. He is capable of making a good will so long as he remains of sound mind and is not acting under fraud or duress. He may find many reasons why the distribution of his estate under the laws of descent and distribution would not be satisfactory.

If he has no will his property will go to his relatives, in accordance with the law. If he has no relatives his property will escheat to the state. That is, the state will become the absolute owner after the fact is established in the manner provided by law that there is no relative who is entitled to it under the laws of inheritance. Relationship, so far as the law of inheritance is concerned, goes as far as it can actually be traced and proved. The state is the source of all title to real estate, and in the absence of any heir capable of inheriting the real estate from a deceased person who left no will, the title goes back to the state whence it originally came.

Without going into unusual situations but covering the somewhat common situations where one dies intestate, that is without a will, the following is set out to illustrate the laws of inheritance:

1. A widow inherits from her husband as follows:

(a) If he leaves no issue and no parents, all the estate;

(b) If he leaves no children, three-fourths if father and/or mother survive him and net estate exceeds $1,000;

(c) If he leaves widow and one child or its issue, one-half of all property, $500, occupancy of dwelling, and forty acres for one year;

(d) If he leaves a widow and children and/or issue of children, one-third of all property, $500, occupancy of dwelling, and forty acres for one year.

2. A subsequent childless widow inherits:

(a) If husband dies without issue, same as first widow;

(b) If husband leaves children, one-third of the real estate for life with the remainder to the children of decedent or their issue, and one-third of the personal property plus $500.

3. A widower inherits from his wife who dies without any issue the same as the widow would inherit from the husband:

(a) If wife leaves surviving widower and one child or more and/or issue of one child or more, one-third of all real and personal property, subject to wife's antenuptial debts.

There is a complete table of inheritance set out on pages 358 and 361 of Burns Indiana Statutes, 1933. The remainder of the information contained in that table may be condensed into the statement that all heirs of the same degree share equally in an estate, while heirs unequal in degree take per stirpes. That is, they take the shares their parents would have taken if alive.

This general statement is highly condensed, and for a full understanding would require a somewhat extended additional discussion. But this will serve to illustrate the effort of the law to reach a satisfactory distribution of property in the absence of a will. It may be entirely satisfactory in many cases. But frequently there are special considerations to which weight should be given in carrying out the purpose of providing for one's family or for other use of his property, after he is gone.

Suppose one of the children is a cripple and so handicapped as to be unable to care for himself, while the others are well endowed with capacity to provide for themselves without help. Or suppose that some very cogent reason exists why one child should not come into his entire inheritance all at once with the full power to dispose of it as he sees fit. A spendthrift trust should be considered through which his inheritance may be protected and dealt out to him as his needs may require. Or suppose some daughter married a worthless rascal who promoted the marriage with the ambition of retiring immediately after the wedding, in the hope of being supported by her prosperous father as long as he lives and then through her share of her father's estate.

One could multiply the circumstances and conditions which would reasonably prompt thoughtful and considerate parents to make some provisions regarding future interests. There are very few estates in which the entire purpose of the testator, the maker of the will, can be made fairly certain of being carried out, without a careful consideration of the possibilities which the future holds for the wrecking of his best laid plans.

So the making of a will requires greater pains and more thorough study than any other document a lawyer is called upon to draft. Too much publicity has been given to the idea that a will ought to be short and that the shorter it is the better it is.

This one hypothetical example will illustrate and prove how futile a short will may be to accomplish the purpose of the testator:

> Mrs. X had a husband and one daughter. Mr. X retained some extraordinarily youthful ideas. Mrs. X was extraordinarily tolerant and devoted to her husband but she knew of his exuberant interests in a woman considerably younger than he was. She saw her lawyer about it, not for the purpose of obtaining a divorce but for the purpose of having a will drawn which she wanted to be just a short will under which she would give everything to her daughter. A will to effect that purpose could be drawn in the words, "I will my property to my daughter." Then of course it would have to be signed and witnessed. That would be enough to make a will of all her property to her daughter.
>
> The daughter and her mother later are riding in an automobile and have an accident in which the mother is instantly killed. A short time after the death of the mother the daughter died from her injuries from the same accident, leaving no children surviving.

Now consider the legal situation, under which the property of the mother vested immediately upon her death in the daughter, subject to the mother's debts. Then the daughter died and her only heir was her father. The property immediately vested in him.

Then the husband, feeling the warmth of spring in his veins, shortly thereafter marries the woman whom he had been interested in before; and while the estate of his first wife, which had been bequeathed to the daughter and descended from her to him, is being settled, he dies leaving no one as his heir but the woman, and she gets the estate—a result the deceased wife particularly wanted to avoid. What should have been done in this hypothetical case?

Mrs. X should have told her lawyer all the facts in the case, including the fact that inasmuch as she had a substantial estate she did not want her husband to go without the necessities to sustain him in a comfortable standard of living; and also the fact that she did not want her husband to be in any position in which her property could be transferred to him as a result of his death, or the death of anyone else. This would have required the careful drafting of some future interests provisions. She could have willed the property to her daughter subject to certain limitations which would provide that the daughter would maintain and support her father from the estate to the extent that it would be necessary to maintain the standard of living to which he was accustomed. She could have included in the will a limitation upon any power of the daughter to will or give the property to her father, and at the same time she could have made provision for the property to go to contingent beneficiaries in event of the death of the daughter with the burden still on the estate for the support of her husband. A carefully drawn will to cover these provisions would require several pages and a diligent study of the possibilities of future interests in the estate, and also an imagination through which future incidents might be anticipated and provision made in regard to them.

The justification for this article is in the fact that we have seen some of the results of the failure of people to make a reasonable effort to anticipate and provide to meet future conditions which may arise to defeat their purposes—with the result that—

> "The best laid schemes o' mice and men
> Gang aft a-gley;
> An' lea'e us nought but grief and pain,
> For promis'd joy."

So when making your will, get a lawyer to help. Bring all the facts together and ask your lawyer to put some of the art of law into the will,—and not just the mere artisan work of incorporating the formal requirements into an inadequate statement of your purpose and the means by which you desire to accomplish it.

The schedule for the Instructional Course Program will will be found on page 621

SOME NONMEDICAL OBLIGATIONS OF PHYSICIANS

THE term "medical obligations" is used to designate the concept which doctors have of their obligations to their patients because of the physician-patient relationship. Those obligations have been discussed in previous Year Books of this association, particularly in relation to the subject of malpractice. But there are other obligations a physician has in addition to those that run only to the patient the physician is treating; and there are also obligations which run both to the patient and to others associated with the patient, which do not have to do with the administration of medicine or the performance of surgery or obstetrics, for the patient. While these other obligations are not well defined in the law through judicial decisions, as is true regarding malpractice, nevertheless there are decisions and statements of judges and law writers which indicate the growth of the law toward an expansion of those obligations of physicians which are not strictly medical obligations.

These developments have their impetus in the same sentiments and reasoning as produced the humanitarian doctrine in the law of negligence. That doctrine is sometimes referred to as the doctrine of the last clear chance. Briefly stated, it means that where two people have been concurrently negligent and one of them as the result of his own negligence is placed in peril, of which peril the other one becomes aware before it is too late to avoid injury to the first, it becomes the duty of the second to do the things which due care requires should be done to prevent injury to the first. Before the adoption of the humanitarian doctrine, which is not followed even yet in all the states of the Union, the rule was that where a person negligently put himself in peril and then was injured through the cause to which he imperiled himself, he cannot recover from the other person, since the negligence of both concurred—even though the second one might have avoided injuring the first by using proper care after he knew of the peril in which the negligence of the first had placed him.

This leads to the inquiry as to how far the law will go in exacting from one person the conduct which would be necessary to protect another.

Suppose a physician is called to treat one member of a family. He comes into the home and sees that some other member of the family whom he has not been called upon to treat is suffering from a contagious disease. What, if any, duty does the physician owe to the other members of the family with whom he has no relationship of physician and patient? Of course he has the duty to obey the rules and regulations of the State Board of Health, a government agency, regarding reporting contagious diseases. But we are now dealing with his obligation, if any, to the members of the family or those who may be in close contact with the members of the family. In addition to reporting the disease, some states have held that the physician has the duty to exercise care in advising and warning other members of the dangers to which they are exposed, and to take suitable precautionary measures to prevent the spread of the disease. The general principle of law involved may remain unchanged, while its application to other states of facts where the general principle itself is applicable may considerably enlarge the duties and obligations of a physician beyond those to whom he definitely owes the duty of giving medical care.

Suppose a physician were called into a family to treat a child and his diagnosis was that the child was suffering from lack of food, which lack could be supplied through the township trustee or welfare department. Or suppose a child is born with a visible congenital deformity. Or let the imagination picture any situation where agencies other than physicians and hospitals should be brought into the case. The physician may occupy such a position with respect to the family, in which he has been employed to treat but one member, that other duties may be imposed upon him besides the mere treatment of the other member—duties to protect, to rehabilitate, and to set other agencies into operation. Duties of this class are well illustrated by the situations that sometimes develop where dangerously insane are involved.

Fortunately there are few instances in which these obligations are not so obvious that they can scarcely escape attention and fail to prompt such conduct as the ordinarily cautious and prudent person would exercise in the practically universal spirit of good-will that permeates nearly all of the human relationships into which the physician comes. It is appropriate, however, to call attention of physicians to the fact that the law has placed upon physicians some special responsibilities which can best be discharged through cooperative contacts with government agencies which exist for the purpose of rendering specialized services in some of these fields. So a general knowledge of who the judges and the prosecuting attorney are and the fields in which their assistance might properly be requested is highly desirable. The same can be said regarding the trustee as the overseer of the poor; the county welfare department, as the organization through which aid may be obtained for dependent and destitute children and for blind and aged; social agencies of a private nature supported by the churches and other charitable organizations; state and local health authorities; the juvenile court; and any other instrumentalities whose services and benefits may contribute to the improvement of the conditions which call for the services these institutions and organizations can provide.

This does not mean that the physician needs to be an expert in these many lines in order to avoid legal troubles. But he does need to exercise the care and caution of the ordinarily cautious and prudent person to avoid unnecessary pain and injury to those who come within that relation to him where he knows, or should know, that trust and confidence is being reposed in him to guide and help the family in the entirety of their health problems.

This article is unavoidably general rather than specific. It is impossible to write a meticulously specific article covering each possible question that might arise in these fields. Law remains general and the boundaries of its application remain vague and indefinite until they are fixed by judicial decisions. In these fields there have been few such decisions; and where they have occurred it has generally been under conditions which would not at all be likely to be repeated. So whatever legal problems affecting physicians may develop in the future in these fields may arise out of general principles with but little of specific guidance from the decisions of the court. This condition will continue until a much larger number of decisions have been absorbed into the general framework of the law in these fields. Until then, the physicians' best protection is in continuing the exercise of their own alert solicitude and interest in whatever may be done for their patients and their families in anything relating to their health and physical condition.

DETERMINATION OF DISABILITY AND IMPAIRMENT

GENERAL RULES OF PROCEDURE BEFORE THE INDUSTRIAL BOARD

Maurice T. Harrell*

Indianapolis

I. GENERAL STATEMENT

THE Administration of the Workmen's Compensation and Occupational Diseases laws is the responsibility of the Indiana Industrial Board. These are the laws under which employees are compensated for accidental injuries or death arising out of and in the course of their employment and for occupational diseases contracted as a result of their employment. The Workmen's Compensation Act establishing the Industrial Board was passed by the Legislature in 1915. The Workmen's Occupational Diseases Act was approved in 1937 and its administration placed under the jurisdiction of the Industrial Board. Under both laws employers are required to insure their employees through private insurance companies or may elect to carry their own risk, but such applications must be approved by the Industrial Board as to liability and financial responsibility.

The Industrial Board of Indiana is composed of five members, not more than three of whom shall belong to the same political party. They are appointed and commissioned by the Governor; are directly responsible to him, and one member is designated as chairman and required to be a lawyer. All members of the present Board were appointed and received a commission from Governor Henry F. Schricker on August 1, 1949.

The Industrial Board is authorized by law to adopt such rules and regulations as may be necessary to carry out with effect the provisions of the Indiana Workmen's Compensation Act and the Workmen's Occupational Diseases Act and to prescribe the means, methods and practices in order to effectuate such provisions. New rules of procedure were adopted by this Board and came into full force and effect on August 10, 1949, with changes made as to continuance of cases, in order to expedite the trial of contested claims.

This Board has developed into a specialized Industrial Compensation Injury Court and its members act in the capacity of judges of mixed questions of law and facts that are involved in all cases. Due to the large number of cases that are continuously filed with the Board, all members devote their full time to the work.

II. DUTIES OF THE INDUSTRIAL BOARD

The Duties of the Industrial Board in general are to hear, determine and review all claims for compensation; to require medical services for injured employees; to approve claims for medical and attorneys fees and charges of nurses and hospitals; to approve agreements; to modify, change or amend awards, to make conclusions of facts and rulings of law; to certify questions of law to the Appellate Court; to approve agreements between an employer and employee or his dependents for the cash payment of compensation in a lump sum, or in the case of a minor, to order such cash payments; to order physical examinations of

* Chairman, Industrial Board of Indiana, Indianapolis.

the claimants; to subpoena witnesses; administer oaths; to apply to the Circuit or Superior Courts to enforce the attendance and testimony of witnesses and the production for examination of books, papers and records; and to exercise all other powers and duties conferred upon it by law.

III. PROCEDURE BEFORE THE BOARD

In case of an injury, the employee immediately contacts the employer, foreman or superintendent where employed, telling him the cause of the injury. If the employer is convinced that the responsibility is his, he sends the employee to a physician and notifies his insurance carrier; at the same time the employer sends to this Board a Form 24, which is a report of the injury. If it is necessary for the injured party to remain away from his employment for more than seven days, then on the eighth day following the injury, compensation should start and continue until he is able to return to work, and in addition he should receive all medical, hospital, doctor and nurse's expense. Cash awards in amounts specified by law are granted in proven cases of injury or occupational disease, or in death resulting from either, when arising out of and in the course of employment.

The same procedure applies in the case of an occupational disease if the employer is convinced it was contracted during and in the course of his employment. However, if in either case the employer refuses to accept responsibility in the matter, the employee may file a claim with this department (what is called a Form 9 for an injury and Form 115 for an occupational disease) and the procedure following in the adjustment of such claims is practically the same as that followed in civil cases, except there are no jury trials. A decision is rendered by the Hearing Judge on the evidence presented at the trial.

If either party is not satisfied, the case may be appealed to the Full Industrial Board, at which time all the judges sit on the bench and the case is reviewed before them, and a written decision is made either affirming the single member's order or modifying or revising the decision. If this order does not meet the approval of either party it may be appealed to the Appellate Court, or the Supreme Court, if desired, and in practically the same manner as in civil cases.

The Industrial Board will not be bound by the usual common law or statutory rules of pleading and evidence, or by any technical rules of practice in conducting hearings, but will conduct such hearings and make such investigations in reference to the questions at issue in such manner as in its judgment are best adapted to ascertain and determine expeditiously and accurately the substantial rights of the parties, and to carry out justly the spirit of "The Indiana Workmen's Compensation Act" and "The Indiana Workmen's Occupational Diseases Act."

IV. SECOND INJURY FUND

The Second Injury Fund law was enacted by the 1949 Legislature and became effective June 1, 1949. It provides that if an employee who from any cause, whether in line of employment or otherwise, had lost or loses the use of one hand, one arm, one foot, one leg, or one eye, and in a subsequent industrial accident becomes permanently and totally impaired by reason of the loss, or loss of use of another such member or eye, the employer shall be liable only for the compensation payable for such second injury; provided, however, that in addition to such compensation and after the completion of the payment therefor, the employee shall be paid the remainder of the compensation that would be due for such total permanent impairment out of a special fund known as the "Second Injury Fund."

The Second Injury Fund of Indiana is financed by an assessment on every insurance company writing Workmen's Compensation in Indiana and every employer who carries his own risk. Only two annual assessments will be necessary to create a fund of $50,000 required under the statute.

The problem of insuring jobs and rehabilitating physically handicapped workmen is and should be of deepest concern to the American people. The present-day need for manpower necessitating the employment of the maimed and crippled civilians and former service veterans is the main reason for passing this law. The establishment of the Second Injury Fund protects the employer who hires handicapped workmen against higher workmen's compensation costs. Employers have been reluctant to hire or rehire a handicapped person. Unfortunate handicapped workmen should be given every opportunity to earn a decent and respectable livelihood in conformity with the American standard of living. Through the establishment of the special Second Injury Fund the workers are protected and employers carry only the normal cost of accident while the added cost of the cumulative effects of the second injury will be borne by the fund. Thus the fund not only eliminates the fear of employers to hire physically handicapped persons, but it also adequately protects the handicapped employee and greatly assists him in finding employment suitable to his ability and capacity.

V. DETERMINATION OF DISABILITY AND IMPAIRMENT

A. *Temporary total disability* is the inability to work or loss of time as a result of an accidental injury received, but compensation is allowed after seven days and beginning on the eighth day; however, compensation will be allowed for the first seven days only if the disability continues for longer than twenty-eight days.

B. *Impairment* is the partial or total loss of function of any part or member of the body, or the body as a whole; or an amputation of any member

or part of a member of the body. Impairment relates to the loss of functions of the body, whether functions pertain to work or play and not as to whether he has the ability to resume his former job. Permanent partial or total impairment means just what it says, that the patient has reached a quiescent stage and if not, then the percentage is impossible to appraise. The accidental injury must arise out of and in the course of the employment.

The employer shall furnish or cause to be furnished to the injured employee free of charge, immediately following the accidental injury and during the first 180 days, an attending physician for the treatment of his injuries and in addition thereto such surgical, hospital and nurse's services and supplies as the attending physician or the Industrial Board may deem necessary. The medical attention may continue to be furnished by the employer during the whole or any part of the remainder of the period of disability or impairment resulting from the injury.

Where a compensable injury results in the amputation of an arm, hand, leg or foot, or the enucleation of an eye, or the loss of natural teeth, the employer shall furnish an artificial member, and where required proper braces.

The injured employee shall be examined by a duly qualified physician engaged by the employer; and where the employee engages a physician for an examination and both physicians so engaged are not present at the time of the examinations, then the written statements shall be exchanged by employer and employee, within seven days of the examinations but not later than ten days before the time the case is set for hearing. If the employer desires to have an additional medical examination of the employee such examination shall be no later than 10 days prior to the day the case is set for hearing; and if the examination is by specialists the employer must pay the necessary travel expenses of the employee to and from the place of examination and also such loss of wages, if any.

For injuries causing temporary total disability for work there shall be paid to the injured employee during such total disability a weekly compensation equal to 55 percent of his average weekly wages for a period of not to exceed 500 weeks; not to exceed a maximum weekly wage of $23.10.

For injuries causing temporary partial disability for work, compensation shall be paid to the injured employee during such disability, a weekly compensation equal to 55 percent of the difference between his average weekly wages and the weekly wages at which he is actually employed after the injury, for a period not to exceed three hundred weeks. In case the partial disability begins after the period of temporary total disability, the latter period shall be included as a part of the maximum period allowed for partial disability.

C. *Compensation Schedule For Particular Results of Injuries—Section 31 of Workmen's Compensation Act.*

(a) For injuries in the following schedule the employee shall receive *in addition to temporary total disability benefits not exceeding twenty-six weeks* on account of said injuries, *a weekly compensation of 55 percent of his average weekly wages* for the periods stated for said injuries respectively, to wit:

(1) *Amputations:* For loss by separation,

Thumb	60 weeks,
Index finger	40 weeks,
Second finger	35 weeks,
Third or ring finger	30 weeks,
Fourth or little finger	20 weeks,
Hand by separation below the elbow joint	200 weeks,
Arm above the elbow	250 weeks,
Big toe	60 weeks,
Second toe	30 weeks,
Third toe	20 weeks,
Fourth toe	15 weeks,
Fifth toe or little toe	10 weeks,
Foot below the knee joint	150 weeks,
Leg above the knee joint	200 weeks.

Loss of *more* than one phalanx of a thumb or toe—considered loss of entire thumb or toe.

Loss of *more* than two phalanges of a finger—considered as loss of the entire finger.

Loss of *not* more than one phalanx of a thumb or toe—considered as the loss of ½ of the thumb or toe and compensation shall be paid for ½ of the period for loss of the entire thumb or toe.

Loss of *not* more than one phalanx of a finger—considered as the loss of ⅓ of the finger and compensation shall be paid for ⅓ the period for the loss of the entire finger.

Loss of *more* than one phalanx of the finger but not more than two phalanges of the finger, shall be considered as loss of ½ of the finger and compensation shall be paid for ½ of the period for the loss of the entire finger.

(2) Loss by *separation* of *both* hands or both feet or the sight of both eyes, or any *two* of such losses in the same accident ..... 500 weeks.

(3) Permanent loss of the sight of an eye or its reduction to 1/10 of normal vision with glasses ..... 150 weeks.

(4) Permanent and complete loss of hearing in one ear ..... 75 weeks; and in both ears ..... 200 weeks.

(b) For injuries in the following schedule, the employee shall receive in lieu of all other compensation on account of said injuries a weekly compensation of 55 percent of his average weekly wages for the period stated for said injuries respectively, to-wit:

(1) *Loss of use:* The total permanent loss of the use of an arm, hand, thumb, finger, leg, foot,

toe or phalanx shall be considered as the equivalent of the loss by separation of the arm, hand, thumb, finger, leg, foot, toe or phalanx, and compensation shall be paid for the same period as for the loss thereof by separation.

(2) *Partial loss of use:* For the permanent partial loss of the use of an arm, hand, thumb, finger, leg, foot, toe, or phalanx, compensation shall be paid for the proportionate loss of the use of such arm, hand, thumb, finger, leg, foot, toe, or phalanx.

(3) Injuries resulting in total permanent disability ..... 500 weeks.

(4) *Any permanent reduction of the sight of an eye* less than a total loss as specified in paragraph (3) of section 31(a) compensation shall be paid for a period proportionate to the degree of such permanent reduction.

(5) For any *permanent reduction of the hearing* of one or both ears, less than the total loss as specified in paragraph 4 of section 31(a) compensation shall be paid for a period proportionate to the degree of such permanent reduction.

(6) All other cases of permanent partial impairment, compensation proportionate to the degree of such permanent partial impairment, in the discretion of the Industrial Board, *not exceeding 500 weeks.*

(7) *All cases of permanent disfigurement,* which may impair the future usefulness or opportunities of the employee, *compensation, in the discretion of the Industrial Board, not exceeding 200 weeks,* except that no compensation shall be payable under this paragraph where compensation is payable elsewhere in section 31.

D. Examination by Disinterested Physician or Surgeon.

The Board or any member thereof may, upon the application of either party or upon its own motion, appoint a disinterested and duly qualified physician or surgeon to make any necessary medical examination of the employee and to testify in respect thereto. Said physician or surgeon shall be allowed traveling expenses and a reasonable fee to be fixed by the Board not exceeding ten dollars for each examination and report, but the Board may allow additional reasonable amounts in extraordinary cases.

The fees and expenses of such physician or surgeon shall be paid by the state only on special order of the Board or a member thereof.

E. Report of Attending Physician.

Compensation Agreements in all cases of amputations, permanent impairment or permanent partial impairment shall have attached thereto when filed with the Industrial Board a report of a physician furnished by the employer and also a report of a physician employed by and representing the employee unless such report is waived in writing by such employee as to such amputation or their opinions of percent of permanent impairment or permanent partial impairment, unless such reports have been previously filed. When so filed, such agreement will be approved or set down for hearing in the discretion of the Industrial Board.

Hernia is a disability that, under the Workmen's Compensation Act, the employee must submit to an operation for the repair of the hernia, unless he can show by competent evidence that his health would be endangered, that is, that he had heart trouble, or that the operation would be futile in correcting the disability.

F. Medical Testimony at Industrial Board Hearings.

Physicians testifying at hearings before the Hearing Judges of the Industrial Board should bring their case notes with them, which would include the following:

(1) History of the case and information as to the nature of the injury resulting from an accident arising out of and in the course of the employment.

(2) Description of medical tests given, i.e., x-rays, blood test, blood count, urinalysis, cardiograms, reflex test, eye test, blood pressure, Wassermann and other tests, if any, and the *findings.*

(3) Diagnosis and treatment, including medication.

Prior to testifying, the physicians should be thoroughly familiar with Section 31 of the law, which sets out the schedule of maximum limits of compensation for particular results of injuries. They should be familiar with certain medical tests or at least be well read on the subject, and should give a fair and impartial opinion.

Testimony as to the percentage of impairment should be based on the following factors or points of consideration:

(1) The definite injury or loss of particular members of the body.

(2) Loss of movement or function of particular members of the body as related to other parts of the body.

(3) General health conditions of employee as a result of the accidental injury.

(4) Diagnosis based on history of case, treatment and medication.

(5) Opinion as to length of disability.

(6) Opinion as to whether or not injury will result in a permanent impairment.

(7) Finally, the evaluation of the above factors, conclusions and opinions, in order to determine the proper percentage of impairment to the particular member of the body—or in case the employee is totally disabled—then the evaluation of the above points should be the percentage of the man as a whole.

Physicians must remember that they are limited

in their partial impairment percentage opinion estimates to the maximum number of weekly payments provided in the Section 31 schedule. In multiple injuries, i.e., the loss of a thumb and little finger, the total would be the scheduled losses plus an additional 10 to 30 percent added to the weeks as a result of the functional loss to the other digits and to the hand as a whole. The more fingers involved, the greater the impairment: 60 weeks for the thumb, plus 20 weeks for the little finger, plus 10 percent, would total 90 weeks. The physician should be prepared in cases involving older employees, for questions as to whether the injury or impairment is due to pre-existing ailments, such as arthritis, or to the injury itself, and whether the injury aggravated the prior condition or not.

THE PLACE OF MEDICAL PARTICIPANT COMMITTEES IN THE ADMINISTRATION OF THE MEDICAL ASSISTANCE PROGRAM

Maurice O. Hunt*

INDIANAPOLIS

THE following statement was prepared by the Indiana State Department of Public Welfare and approved by the State Advisory Committee on Medical Assistance on May 11, 1950, for release to the several state associations representing medical participants.

In the administration of their medical assistance plans, the State and County Welfare Departments have found very useful the advice and suggestions of local doctors and of their medical advisory or technical committees. With the development of the medical assistance program, there has come increasing realization of the need for continuing medical or technical advice. The background and training of the social worker does not equip him to make or appraise medical decisions. County directors are required to sign each report of services submitted by a medical vendor, certifying that the claim has been audited, found to be correct and in accordance with the medical aid plan of the county, and to certify it for payment. When the claim clearly falls within the plan, both as to type of treatment and fees, the nonmedical person would nevertheless be unable to determine whether the amount of care given is proper and necessary. When the claim does not appear to come within the scope of the plan, a nonmedical person needs professional consultation to decide whether or not the claim should properly be paid.

In Indiana the welfare departments provide financial assistance for the aged, blind, and dependent children. This assistance is in the form of money—by a check—and is based on a budgetary need. The maximum money payment allowed by law for the aged and blind is $50 a month; for dependent children, $50 for mother and one child, and $18 for each additional child.

The General Assembly recognized that these amounts were not sufficient to buy food, clothing, shelter and other living needs, and also take care of medical bills, so the law was amended in 1941 to make it possible for the county departments of public welfare to provide money for medical bills over and beyond the amount of the regular assistance award.

Each county department of public welfare draws up a plan for providing medical care for the recipients of public assistance and these plans are submitted to the State Department for review and approval. All the plans provide for free choice of medical vendor by the recipient. The fees for service are arrived at jointly between the county department and the medical vendors and are not to exceed the usual and ordinary fees charged for the same service to other people in the community. There are 92 counties in the state of Indiana and each county plan varies in accordance with the needs and facilities of each county. Some of the counties provide all-inclusive medical care and some of the counties provide only the services of physicians and hospitals. In some counties there has been an attempt made to limit the amount of service for which the county department will be responsible for payment. For example, in some counties for a hospitalized patient, the county will be responsible for payment for daily calls by the physician during the first week of hospitalization, for payment for three calls a week during the

* Administrator, Indiana Department of Public Welfare, Indianapolis.

second week of hospitalization, and for payment for one call weekly thereafter.

At the time the counties began to develop medical assistance plans in late 1941 and 1942, every county department had the assistance of a general advisory committee, made up of doctors, dentists, druggists, nurses, hospital superintendents, and representatives of other interested agencies in the community. These committees rendered valuable service in assisting the county departments to set up sound plans for medical care. In several counties committees themselves, as well as the county departments, recognized the value of such service and have continued to be active. In many counties, however, the committees fell into disuse after the plan began to function.

About 35 counties had approved medical assistance plans by the end of 1942. Gradually other counties developed plans and by February 1, 1949, all 92 county departments had approved medical aid plans. Some of the counties that started out with two or three medical services gradually added other services until now the usual services furnished are those of physicians, dentists, hospitals, nurses, nursing homes, ambulances, and pharmacists. With the increase in the number of counties providing medical care and with the increase in number of services being furnished, there has also been an increase in the total cost of the program. In 1943 the total medical expenditures were $713,222.81; in 1945, $1,222,254.25; and in 1949, $3,335,814.16. The percentage of recipients receiving medical care per month has also increased from an average of 7.6 percent in 1943 to 13.7 percent in 1945 to 20.9 percent in 1949. The average cost per recipient per month has increased from $.65 in 1943 to $1.42 in 1945 to $3.71 in 1949.

With the growth of the program and increase in expenditures, there have come expressions of growing apprehension that the program is going beyond the limits of providing only necessary medical care and that the expenditures will exceed the ability of the counties to support them. This concern has been experienced in the county departments, the state department, state advisory committee on medical assistance and among other public officials. The money for medical care is appropriated by the various county councils and it is derived from property taxes. The state and federal governments help to pay part of the costs. If a county pays the medical bills by giving the money to the recipient, the federal and state governments contribute about 80 percent and if the county department pays the medical bill by sending the check directly to the medical vendor, the state pays 60 percent and the county 40 percent. To meet this growing concern, attempts have been made to introduce limitations on the amounts and kinds of service for which payment will be made. The application of such limitations to specific cases involves medical decisions, however, and again points up the need for participant committees.

There are many situations arising constantly where professional advice and consultation is needed, not only in relation to individual cases but also as to general policies and direction of the program. In one instance a question arose around the continued refilling of a prescription for a particular recipient who had not seen the physician for several months. The discussion of the case in question led to a policy that prescriptions were not to be refilled unless the physician so specified and indicated the number of refills. All pharmacists and physicians were so advised in writing.

A problem that faced another county director in reviewing claims for services furnished was a bill for treatment of a hip fracture. The fee schedule provided for the use of a cast. Some of the physicians were sending in claims indicating the use of the open reduction with pins and the fees were higher. The county director didn't know whether this was a luxury type of treatment or the proper type of treatment. He presented his problem to his medical reviewing committee and they unanimously agreed that the use of the pins was not luxury treatment and explained to him that for old people one of the most desirable things is to get the person on his feet as soon as possible. With the use of the pin, it was possible for the patient to get on his feet within ten days. The doctors agreed to a fee schedule for this type of treatment which was later presented to the county board and approved and likewise approved by the state department.

Another example of the use of medical advisors was a claim that came in from a hospital showing a charge for one day in a ward and the remaining days in a private room. The agreement between the hospital and the county department was that wards were to be used. The report from the doctor indicated that this patient was hospitalized for a hip fracture. The county director called the hospital superintendent who said that the patient was moved to a private room when a routine chest x-ray revealed tuberculosis. The county director brought this to the attention of his medical committee and asked if this was proper use of a private room. The doctors explained to the director that since the local hospital had no isolation facilities, an active tuberculosis case could not remain in a ward but would have to be placed in a private room.

The medical assistance program is a relatively recent innovation although we have had, throughout the history of our country, various programs for providing medical care to people who were unable to pay for their own care. The medical assistance program is similar to private medical care in that the patient has a right to go to any medical participant of his choice, and the medical participants have the choice of accepting the pa-

tient or not accepting the patient; but it differs from private care in that a third party, the county welfare department, pays the bill. The medical assistance program is similar to other public medical programs in that it is financed from tax funds, but it differs in that it is being administered by a nonmedical agency. It has become increasingly apparent that if this type of program is to operate effectively and to the best interests of the total community, the medical participants need to play a vital role in appraising and guiding the program in addition to furnishing services to individual recipients. The State Advisory Committee on Medical Assistance, representing physicians, dentists, nurses, pharmacists, hospitals, the judiciary, and the public at large is giving valuable service in guiding and advising on medical assistance policies at the state level. Since the program is administered at the county level, however, county committees are needed also. The composition and functions of such committees will vary with the needs and the medical assistance plans of the different counties. The entire community has a stake in securing the best health for the money spent and for limiting expenditures on the basis of informed judgment rather than arbitrary decisions.

It is for these reasons that the state department of public welfare is again urging all county departments of public welfare to secure medical participant committees and we are asking the various state associations to request that local societies and local members actively participate in committees to help the county departments effectively discharge the responsibilities delegated to them by law.

COUNTY DEPARTMENTS
TOWNSHIP TRUSTEES RELATIONSHIPS
MEDICAL CARE

THE following statements are excerpts and paraphrased statements from a letter written by the State Department of Public Welfare in answer to an inquiry from a county director who asked about the responsibility of the county department for providing hospitalization for medically indigent persons over 65 years of age and medically indigent children not recipients of other types of welfare assistance under 16 years of age or under 18 years of age if the child is in school:

Sections of the Poor Relief Act (Ch. 116, Acts 1935 as amended; Burns 52-144 to 52-181) concerning the duties of township trustees as overseers of the poor make clear that the mandatory duty of furnishing necessary medical and surgical care not otherwise available rests with the township trustee as overseer of the poor. There are, however, related laws administered through the county department of public welfare which while of a permissive nature imply some responsibility of the county department in certain situations.

Admission to the . . . County Hospital of indigent needy persons where public funds are to be obligated should be under a definite assumption of liability by the township trustee or the county department of public welfare. If public funds are to be charged with the cost of such care, application, investigation and determination of eligibility should be made before the service is rendered except in emergency situations which do not permit such procedure. If admission to the . . . County Hospital is made for a person eligible under the poor relief or welfare laws in an emergency situation, the responsible agency should be notified promptly of such fact so that they can make the necessary determinations and issue the proper authorization. In such situations the . . . County Hospital is presumed to be proceeding under the provisions of Section 22-3206, Burns 1947 Pocket Supplement, Burns Annotated Statutes. (Sec. 3, Ch. 61, Acts 1945.)

The county department of public welfare in furnishing medical care operates under two bodies of law. (1) The Welfare Act of 1936 as amended and (2) Chapter 300 of the Acts of 1947 concerning medical, surgical or hospital care for certain persons to the Indiana University Medical Center or to local public hospitals as defined in the act. Section 34 of the Welfare Act of 1936 as amended, concerns medical care to recipients of old age assistance. Similar provisions are included in Section 54 concerning assistance to the blind and Section 72 concerning assistance to dependent children in custody of relatives. . . .

Commitment under the provisions of Chapter 300 of the Acts of 1947 (section 1) is within the determination of the county department of public welfare, subject to the right of appeal to the circuit court. . . .

It is possible for the person requiring hospitalization and necessary medical care to make an application under the poor relief law to the township trustee. Both the county department of public welfare and the township trustee can furnish such care to eligible persons in need who meet the eligibility requirements of the respective laws. The same statement seems to apply to the child who is not a recipient of assistance to dependent children.

We call your attention to the general statement found in Chapter 1, page 1, of the Manual for Hospital Placement and Commitment issued by the State Department of Public Welfare on November 1, 1948, which reads in part as follows:

> "The county department may place any eligible child in a hospital, regardless of whether or not he is receiving assistance, is a ward, or a destitute child.
>
> "The county department may commit any eligible adult or child to the Indiana University Medical Center or local public hospital, regardless of whether or not he is receiving assistance, is a ward, or a destitute child."

Necessary medical care may be furnished to children who are supported under authorization of the court in accordance with the provisions of Section 19 of the juvenile court act as amended (Burns 9-1319; sec. 1, ch. 267, Acts 1949) or recipients under the destitute children program (Section 97c of the Welfare Act of 1936 as amended; Burns 52-1269.)

There is also a program for the placement of crippled children by the county department of public welfare in the Indiana University Medical Center or at legally established placement centers for the hospitalization of such crippled children.

It is apparent that no general statement can be made that the hospitalization of all medically indigent persons over age 65 is the responsibility of the county department of public welfare or that the medical care of all persons under 18 years of age is the responsibility of the county department. The county department is somewhat limited in the various laws as to residence and other eligibility requirements. The township trustee is authorized under the provisions of Section 5 of the Poor Relief Act (Sec. 5, ch. 116, Acts 1933, Burns 52-148) to furnish necessary medical care as needed both in the home and in the hospital to any indigent person found within the boundaries of the township for whom necessary medical care is not otherwise available other than by the expenditure of public funds.

There should be an understanding between the county department of public welfare and the township trustees and hospital authorities so that persons requiring medical care will not be shunted from place to place and prompt payment of the expenses of hospitalization and medical care may be made. . . .

TOWNSHIP TRUSTEES—COUNTY DEPARTMENT RELATIONSHIPS—MEDICAL CARE

The following information is from the Township Trustees' Bulletin which is issued monthly by the State Board of Accounts, Indianapolis, Indiana—Number 40—October 1, 1949:

"POOR RELIEF—RELATIONSHIP TO COUNTY WELFARE: The poor relief laws place upon the township trustee the duty of administering relief to poor persons. This duty extends to providing medical and surgical attendance for poor persons who are not provided for in public institutions. There are, however, related laws administered through the county department of public welfare which are of a permissive nature. One welfare act (Ch. 200, Acts 1947—Burns 52-1203) *allows* county departments of public welfare to include in its monthly awards to recipients, amounts of money for medical care. Before so doing, each county department of public welfare is required to establish and submit to the state department of public welfare for review and approval, a plan for furnishing such medical care. Another law (Ch. 300, Acts of 1947—Burns 52-1131) *empowers* county departments of public welfare to commit persons to hospitals for treatment for disease, defect or deformity if the person, or anyone chargeable under law with the responsibility of furnishing medical care is not financially able to defray such expense. It is to be noted that these laws governing county departments of public welfare are not mandatory. It follows that the poor relief load is lessened only to the extent of the burden assumed by the welfare department and the responsibility of the township trustee is lessened only to the extent of services furnished by the welfare department. There should be an understanding between the county department of public welfare and township trustee as to what services the county department has assumed under its plan, if any has been approved. When there is such an understanding, each agency can function within defined jurisdiction with a minimum of duplication of effort and it should not be necessary to cause a needy person to go from place to place in search of the agency responsible for his care. Also, the question as to which agency should be liable for treatment and care can be eliminated. The courts of this state have said that the poor relief laws are humanitarian in purpose. This being true, when a person is found in distress and indigent, regardless of services offered by other agencies, it is the duty of the township trustee to provide relief until aid by such other agency or agencies can be summoned.

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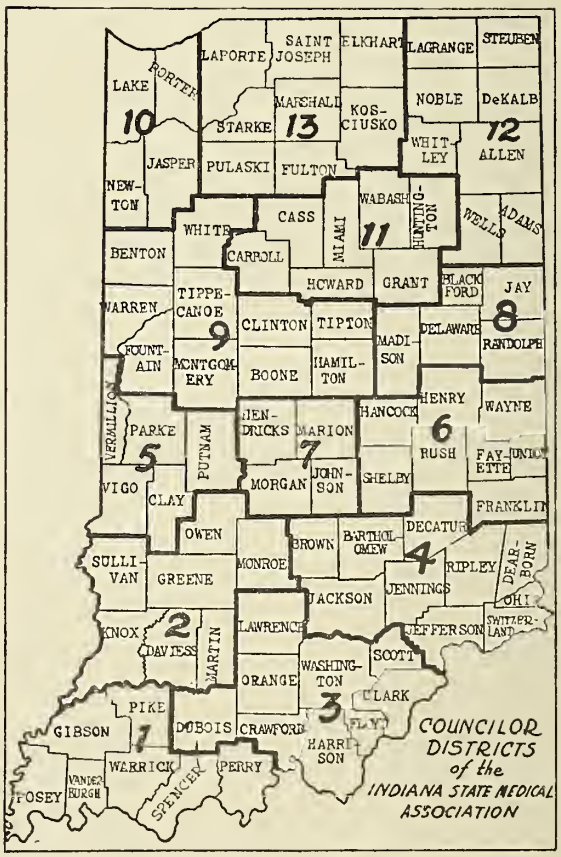

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** Central Area.
*** Southern Area.

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January 1, 1950

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Irene Byron Sanatorium.
R. R. 13, Lima Road North, Fort Wayne.

Mrs. Margaret Schuh, R.N., Supt.
Allen County Isolation Hospital.
R. R. 13, Fort Wayne.

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3024 Fairfield Ave., Fort Wayne.

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St. Joseph Hospital.
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25 Douglas St., Hammond.

Sister M. Alphonsine, Administrator.
St. Mary Mercy Hospital.
540 Tyler St., Gary.

LAPORTE COUNTY

Mr. Ernest I. Hoover, Administrator.
Fairview Hospital Association, Inc.
215 Pine Lake Ave., LaPorte.

H. L. Brooks, M.D., Administrator.
Clinic Hospital.
125-133 E. 5th St., Michigan City.

Sister M. Fidelis, R.N., Administrator.
Holy Family Hospital.
205 "E" St., LaPorte.

Sister M. Albertinia, R.N., Supt.
St. Anthony Hospital
Wabash and Ann Sts., Michigan City.

Mr. Stanley E. Giese, Administrator.
Warren Hospital, Inc.
719 Franklin St., Michigan City.

LAWRENCE COUNTY

Mrs. Helen Boyer, R.N., Supt.
Dunn Memorial Hospital.
1616 23rd St., Bedford.

MADISON COUNTY

Sister Andrea, R.N., Supt.
Mercy Hospital.
1331 South "A" St., Elwood.

Sister M. Margaret Anne, Administrator.
St. John's Hickey Memorial Hospital.
127 W. 19th St., Anderson.

MARION COUNTY

Charles W. Myers, M.D., Supt.
Indianapolis General Hospital.
960 Locke St., Indianapolis.

Mr. J. B. H. Martin, Administrator.
James Whitcomb Riley Hospital for Children.
I. U. Medical Center, 1040-1232 W. Michigan St., Indianapolis.

Mr. Robert E. Neff, Supt.
Methodist Hospital of Indiana, Inc.
1604 N. Capitol Ave., Indianapolis.

George W. Bowman, M.D.
Public Health Center.
1140 E. Market St., Indianapolis.

Mr. J. B. H. Martin, Administrator.
Robert W. Long Hospital.
I. U. Medical Center, 1040-1232 W. Michigan St., Indianapolis.

Very Rev. August R. Fussenegger, Supt.
St. Elizabeth Maternity Hospital and Infant Home.
2500 Churchman Ave., Indianapolis.

Sister M. Alexia, Superior.
St. Francis Hospital.
Sherman Drive and Troy Ave., Beech Grove.

Sister Lydia, Administrator.
St. Vincent's Hospital.
120 W. Fall Creek Parkway, Indianapolis.

Mrs. Ruth Henderson, Executive Director.
Suemma Coleman Home.
2044 N. Illinois St., Indianapolis.

Frank L. Jennings, M.D., Supt.
Marion County Tuberculosis Hospital.
Sunnyside Sanatorium, R. R. 12, Box, 233, Indianapolis.

Mr. J. B. H. Martin, Administrator.
William H. Coleman Hospital for Women.
I. U. Medical Center, 1040-1232 W. Michigan St., Indianapolis.

MARSHALL COUNTY

Mr. Robert Yoder, Supt.
Community Hospital of German Township, Inc.
411 Grant St., Bremen.

Miss M. Virginia McQueen, R.N., Supt.
Parkview Hospital.
1401 N. Michigan St., Plymouth.

MIAMI COUNTY

Miss Ethel M. Ewing, Supt.
Dukes-Miami County Hospital.
12th and Grant Sts., Peru.

Donald W. Ferrera, M.D., Surgeon-in-Charge.
Wabash Employees Hospital Association.
North Broadway, Peru.

MONROE COUNTY

Miss Anna G. Nelson, Administrator.
Bloomington Hospital.
640 S. Rogers St., Bloomington.

MONTGOMERY COUNTY

Mr. Ralph M. Hass, Administrator.
Montgomery County Culver Union Hospital.
308 Binford St., Crawfordsville.

MORGAN COUNTY

K. E. Comer, M.D., Supt.
Comer Sanitarium.
130 N. Indiana St., Mooresville.

Mrs. Mabel E. TerBush, R.N., Supt.
Morgan County Memorial Hospital.
190 S. Main St., Martinsville.

NOBLE COUNTY

Harold A. Luckey, M.D., Supt.
Luckey Hospital.
Wolflake.

Sister M. Ludgeria, Administrator.
Kneipp Springs Sanatorium.
Rome City.

Mrs. Jane L. Black, R.N., Supt.
McCray Memorial Hospital.
Hospital Drive, Kendallville.

ORANGE COUNTY

Ivan A. Clark, M.D., Administrator.
Clark Hospital, Inc.
308 E. Main St., Paoli.

PARKE COUNTY

Robert A. Staff, M.D., Supt.
Indiana State Sanatorium.
R. R. 1, Rockville.

PERRY COUNTY

Nicholas A. James, M.D., Supt.
Parkview Hospital.
746 9th St., Tell City.

PORTER COUNTY

Mr. Rex von Krohn, Administrator.
Porter Memorial Hospital.
814 LaPorte Ave., Valparaiso.

PULASKI COUNTY

Thomas E. Carneal, M.D., Administrator.
Carneal's Private Hospital.
111 N. Monticello St., Winamac.

PUTNAM COUNTY

Mrs. Lena McFerren, Supt.
Putnam County Hospital.
322 Greenwood Ave., Greencastle.

RANDOLPH COUNTY

Mrs. Vera M. Maynard, R.N., Supt.
Randolph County Hospital.
Greenville Ave., Winchester.

Mrs. Marcella Kantner, R.N., Supt.
Union City Hospital
702 W. Division St., Union City.

RIPLEY COUNTY

Sister M. Gerard, R.N., Administrator.
Margaret Mary Hospital.
Rosemont Division, Batesville.

William J. Warn, M.D., Administrator.
The Whitlatch Clinic and Hospital, Inc.
Milan.

RUSH COUNTY

Miss Ethel Stinger, R.N., Supt.
City Hospital.
112 E. 5th St., Rushville.

SCOTT COUNTY

Floyd S. Napper, M.D., Administrator.
Napper Hospital.
69 Wardell St., Scottsburg.

SHELBY COUNTY

Mrs. Frances Pruitt, R.N., Supt.
William S. Major Hospital.
150 W. Washington St., Shelbyville.

ST. JOSEPH COUNTY

E. W. Custer, M.D., Supt.
Healthwin Hospital.
R. R. 5, Darden and Laurel Roads, South Bend.

Mr. Alvan A. Sauer, Supt.
Northern Indiana Childrens Hospital.
1234 N. Notre Dame Ave., South Bend.

Mr. Richard Hocking, Administrator.
Memorial Hospital of South Bend.
604 N. Main St., South Bend.

Sister M. Odilo, R.N., Administrator.
St. Joseph Hospital.
215 W. 4th St., Mishawaka.

Sister Miriam Dolores, R.N., Administrator.
St. Joseph's Hospital.
401 N. Notre Dame Ave., South Bend.

A. F. Kull, D.O., Administrator.
South Bend Osteopathic Hospital.
118 S. William St., South Bend.

STEUBEN COUNTY

Mrs. Daisy McCallister, R.N., Supt.
Cameron Hospitals, Inc.
416 E. Maumee, Angola.
Miss Bessie Cottrell, R.N., Administrator.
Elmhurst Hospital, Inc.
909 W. Maumee, Angola.

SULLIVAN COUNTY

Miss Mabel A. Cook, R.N., Administrator.
Mary Sherman Hospital.
320 N. Section St., Sullivan.

TIPPECANOE COUNTY

Mr. T. E. Berg, General Manager.
Lafayette Home Hospital.
2400 E. South St., Lafayette.

Sister M. Sponsaria, Administrator.
St. Elizabeth Hospital
1021 N. 14th St., Lafayette.

J. W. Strayer, M.D., Supt.
William Ross Sanatorium.
State Road No. 52, Lafayette.

VANDERBURGH COUNTY

Paul D. Crimm, M.D., Supt.
Boehne Tuberculosis Hospital.
Upper Mount Vernon Road, Zone 12, Evansville.

Mr. Albert G. Hahn, Administrator.
Protestant Deaconess Hospital.
600-700 Mary St., Evansville.

Sister Justina, Administrator.
St. Mary's Hospital, Inc.
713 First Ave., Evansville.

Mr. Crayton E. Mann, Administrator.
Welborn Memorial Baptist Hospital, Inc.
412 S.E. 4th St., Evansville.

VERMILLION COUNTY

Miss Hannah Rosser, R.N., Administrator.
Vermillion County Hospital.
801 S. Main St., Clinton.

VIGO COUNTY

Mrs. Arlie Dwyer, R.N., Supt.
Florence Crittendon Home
1923 Poplar St., Terre Haute.

J. J. Hoover, M.D., Supt.
Hoover Sanatorium.
2144 8th Ave., Terre Haute.

Sister M. Stephanina, Administrator.
St. Anthony Hospital.
1021 S. 6th St., Terre Haute.

I. Herman Sloss, M.D., Administrator.
Sloss Hospital.
1029 S. 7th St., Terre Haute.

Mr. Frank R. Briggs, Administrator.
Union Hospital, Inc.
7th St. at 8th Ave., Terre Haute.

WABASH COUNTY

Mr. John H. Blake, Administrator.
Wabash County Hospital.
670 N. East St., Wabash.

WARREN COUNTY

Mrs. Nellie O. Rudolph, Administrator.
The Community Hospital.
412 N. Monroe St., Williamsport.

WAYNE COUNTY

Mr. Frank G. Sheffler, Administrator.
Reid Memorial Hospital.
Spring Grove, Richmond.

J. Nelson Ewbank, M.D., Supt.
Smith Esteb Memorial Hospital.
R. R. No. 4, Liberty Pike, Richmond.

WELLS COUNTY

Mrs. Phyllis A. Chronister, R.N., Administrator.
Clinic Hospital.
309 S. Main St., Bluffton.

Miss Dortha Stewart, Supt.
Wells County Hospital.
1116 S. Main St., Bluffton.

WHITLEY COUNTY

Mr. Carl F. Arntson, Administrator.
Memorial Hospital.
215 E. Van Buren St., Columbia City.

ACCREDITED SCHOOLS OF NURSING

May, 1950

School of Nursing and Hospital, University or College with which School is connected	Location	Director, School of Nursing	Daily Patient Census
***St. Catherine	East Chicago	Miss Marie E. Hickey, R.N.	300
Protestant Deaconess	Evansville	Miss Thelma Brittingham, R.N.	216
St. Mary's	Evansville	Sister Georgiana, R.N.	153
Welborn Memorial Baptist	Evansville	Mrs. Madeline T. Kinney, R.N.	98
aLutheran	Fort Wayne	Miss Pauline G. Bischoff, R.N.	216
Methodist	Fort Wayne	Miss Marie Kolter, R.N.	129
St. Joseph's	Fort Wayne	Sister M. Theodorita, R.N.	300
Methodist	Gary	Miss Emily Stockford, R.N.	224
St. Mary Mercy	Gary	Sister M. Vitalis, R.N.	219
St. Margaret	Hammond	Sister M. Florianne, R.N.	242
Indiana University Training School for Nurses	Indianapolis	Miss Jean L. Coffey, R.N.	536
aIndianapolis General	Indianapolis	Miss Elizabeth C. Wivel, R.N.	576
Methodist	Indianapolis	Miss Fredericka Koch, R.N.	615
St. Vincent's	Indianapolis	Sister Clare, R.N.	365
***aGood Samaritan School-St. Joseph Memorial Hospital	Kokomo	Sister M. Bernadette, R.N.	141
Lafayette Home	Lafayette	Miss Lucille H. Johnson, R.N.	127
aSt. Elizabeth Division of St. Francis College	Lafayette	Sister M. Florina, R.N.	226
***St. Joseph's	Mishawaka	Miss Madelin C. Coleman, R.N.	90
Ball Memorial	Muncie	Miss Clara May Miller, R.N.	246
aHoly Cross Central School	Notre Dame	Sister M. Amadeo, R.N.	
Hospital Units:			
St. John's Hospital	Anderson		
St. Joseph Hospital	South Bend		
St. Mary's Hospital	Cairo, Ill.		
Our Saviour's Hospital	Jacksonville, Ill.		
xxxaSt. Mary's College	Notre Dame	Sister M. Amadeo, R.N.	
Reid Memorial	Richmond	Miss Prudence Appleman, R.N.	138
Memorial Hospital of South Bend	South Bend	Miss Elsie Norman, R.N.	208
St. Anthony	Terre Houte	Sister Mary Nora, R.N.	159
Union	Terre Haute	Miss Emily Gifford, R.N.	174
Good Samaritan	Vincennes	Mrs. Zilpha Miller Burnett, R.N.	110

a Negro students are enrolled.
*** Not admitting students.
xxx Collegiate program.

NEW NURSE TRAINING SCHOOL

St. Mary's College at Notre Dame, Ind., will open the new Holy Cross Central School of Nursing, on September 1. Four hospitals will provide facilities for clinical practice in surgical, medical, obstetric, and orthopedic nursing. Affiliations are to be arranged for pediatric, psychiatric, tuberculosis or communicable disease nursing and for public health nursing in rural districts. The program will be directed by the St. Mary's College Department of Nursing Education.

Students will spend the first nine months at St. Joseph's Hospital in South Bend and will have classroom and laboratory work at the hospital school and at the college. After a four-week vacation, they will have experience in the four hospitals: St. Joseph's in South Bend, St. John's Hickey Memorial in Anderson, Our Saviour's in Jacksonville, Ill., and St. Mary's in Cairo, Ill.

At the end of the three-year program, students will have earned 98 credits toward a B.S. degree.

Indiana Delegation in Congress

UNITED STATES SENATORS*

Senior Senator—Hon. Homer E. Capehart.
(R) Washington, Indiana.

Junior Senator—Hon. William E. Jenner.
(R) Bedford, Indiana.

* Address them at Senate Office Building, Washington, D. C.

UNITED STATES REPRESENTATIVES†

First District—Hon. Ray J. Madden.
(D) 578 Broadway, Gary.

Second District—Hon. Charles A. Halleck.
(R) Rensselaer.

Third District—Hon. Thurman C. Crook.
(D) 311 Fulton Court, South Bend.

Fourth District—Hon. Edward H. Kruse, Jr.
(D) 610 Ft. Wayne Bank Bldg., Ft. Wayne.

Fifth District—Hon. John R. Walsh.
(D) 505 Citizens Bank Bldg., Anderson.

Sixth District—Mrs. Cecil M. Harden.
(R) Fifty and Liberty Streets, Covington.

Seventh District—Hon. James E. Noland.
(D) 420 S. Fess St., Bloomington.

Eighth District—Hon. Winfield K. Denton.
(D) 957 E. Powell Ave., Evansville.

Ninth District—Hon. Earl Wilson.
(R) Bedford.

Tenth District—Hon. Ralph Harvey.
(R) R. R. 4, New Castle.

Eleventh District—Hon. Andrew Jacobs.
(D) Indiana Pythian Bldg., Indianapolis.

† Address them at House Office Building, Washington, D. C.

LICENSED PRIVATE MENTAL INSTITUTIONS IN INDIANA

Mt. Mercy Sanitarium (35 beds)
1628 Ridge Road.
Hammond, Indiana
(temporary license)

Norways Sanatorium (34 beds)
1800 East 10th Street
Indianapolis

Theodora Given Hospital (15 beds)
1523 Broadway
Indianapolis

Clearview (28 beds)
P. O. Box 837, Kratzville Road.
Evansville
(temporary license)

The Retreat (Alcoholic) (14 beds)
41 West 32nd Street.
Indianapolis

Wabash Valley Sanitarium (60 beds)
Lafayette
(temporary license)

INDIANA STATE MENTAL INSTITUTIONS

Central State Hospital (2,339 beds)
Indianapolis
Dr. Max A. Bahr, Supt.

Evansville State Hospital (1,222 beds)
Evansville
Dr. John H. Hare, Supt.

Logansport State Hospital (2,284 beds)
Logansport
Dr. John A. Larson, Supt.

Madison State Hospital (1,519 beds)
North Madison
Dr. M. W. Kemp, Supt.

Richmond State Hospital (1,570 beds)
Richmond
Dr. Paul D. Williams, Supt.

Ft. Wayne State School (1,928 beds)
Ft. Wayne
Mr. Luther T. Hurley, Supt.

Muscatatuck State School (1,461 beds)
Butlerville
Mr. Maurice O'Bannon, Supt.

Indiana Village for Epileptics (1,015 beds)
New Castle
Dr. W. C. Van Nuys, Supt.

(All numbers are approximate.)

PRIVATE NURSING HOMES IN INDIANA*

ADAMS COUNTY

Berne Nursing Home.
906 W. Main St., Berne.
Walter and Maxine Winchester, R.N.
License expires: 8-20-50.

ALLEN COUNTY

Colonial Nursing Home.
802 W. Berry St., Fort Wayne.
Miss Inez Gross, R.N.
License expires: 4-19-50.

The Crater Nursing Home.
1407 E. Wayne St., Fort Wayne.
Mrs. Pearl Crater.
License expires: 10-21-50.

Grace Convalescent Home.
1529 California Ave., Fort Wayne.
Mrs. Jessie G. Richer.
License expires: 10-31-50.

Lawton Nursing Home.
1649 Spy Run Ave., Fort Wayne.
Walter C. Buuck.
License expires: 4-28-51.

Munson Home.
336 Madison St., Fort Wayne.
Mrs. Mabel Munson.
License expires: 7-5-50.

Twin Maples Sanitarium.
734 W. Washington Blvd., Fort Wayne.
Mrs. Maude M. Cole.
License expires: 11-18-50.

Yerrick Home for Men.
516 W. 3rd St., Fort Wayne.
Mrs. Gladys Yerrick.
License expires: 10-27-50.

BARTHOLOMEW COUNTY

Brown Nursing Home.
319 Smith St., Columbus.
Mr. Ithamar Brown.
License expires: 11-16-50.

Columbus Nursing Home.
213 4th St., Columbus.
Robert E. Lee.
License expires: 4-16-51.

Luse Nursing Home.
2436 Pearl St., Columbus.
Mrs. Emojean Luse.
License expires: 4-26-51.

Redman's Sanitarium.
R. R. No. 4, Columbus.
Frank A. and Nellie D. Redman.
License expires: 7-26-50.

BOONE COUNTY

Cora's Nursing Home.
121-123 S. East St., Lebanon.
Mrs. Cora Nelson.
License expires: 4-13-51.

English Nursing Home.
304 W. Washington St., Lebanon.
Mrs. Bessie M. English.
License expires: 11-3-50.

Schwinn Nursing Home.
214 S. Pearl St., Thorntown.
Mrs. Pansy Schwinn.
License expires: 4-13-51.

Trammel Nursing Home.
415 N. Clark St., Lebanon.
Mrs. Sarah S. Trammel.
License expires: 2-7-51.

CARROLL COUNTY

The Arzula Flora Nursing Home.
312 W. Main St., Flora.
Miss Ida Arzula Flora.
License expires: 3-16-51.

Good Will Nursing Home.
Corner Main and Monroe Sts., Camden.
Miss Mabel E. Bechdolt.
License expires: 5-24-50.

Mamie Kennedy Nursing Home.
404 S. Center St., Flora.
Mrs. Mamie J. Kennedy.
License expires: 4-11-51.

Porter Nursing Home.
616 E. Monroe St., Delphi.
Mrs. Alsie J. Porter.
License expires: 12-30-50.

CASS COUNTY

Effie Bell Nursing Home.
R. R. No. 2, W. Jackson, Galveston.
Mrs. Effie Bell.
License expires: 6-1-50.

Galveston Nursing Home.
Washington and Sycamore Sts., Galveston.
Effie and Ednabelle Bell.
License expires: 7-19-50.

Huffman Nursing Home.
2533 Broadway, Logansport.
Mrs. Honour Ruth Huffman.
License expires: 3-10-51.

Justice Nursing Home.
227 Cliff Drive, Logansport.
Mr. and Mrs. Martin Justice.
License expires: 5-7-51.

Rest Haven Nursing Home.
731 North St., Logansport.
Miss Olive S. Jones.
License expires: 4-18-51.

Rose Lawn Home.
3026 E. Broadway, Logansport.
Miss Marie Wilsie Thomas.
License expires: 8-23-50.

Van Winkle Nursing Cottage.
421 15th St., Logansport.
Mrs. Ruth Stone Van Winkle.
License expires: 3-2-51.

CLARKE COUNTY

Jeffersonville Nursing Home.
1315 N. Spring St., Jeffersonville.
Miss Virginia Fulkerson.
License expires: 10-21-50.

Keller Home.
403 E. 7th St., Jeffersonville.
Mrs. Florence Keller.
License expires: 7-30-50.

CLAY COUNTY

Brazil Rest Home.
525 E. Mechanic St., Brazil.
Mrs. James Garvin.
License expires: 10-18-50.

CLINTON COUNTY

Colfax Nursing Home.
P. O. Box 826, Main St., Colfax.
Mrs. Francis M. Waggoner.
License expires: 4-11-51.

Harriet Ann Stoker's Nursing Home.
R. R. No. 4, Frankfort.
Mrs. Harriet Ann Stoker.
License expires: 1-20-51.

DAVIESS COUNTY

Mrs. John Meyers Boarding Home.
215 W. Oak St., Washington.
Mrs. John Meyers.
License expires: 4-18-51.

DECATUR COUNTY

Davis Nursing Home.
510 W. Washington St., Greensburg.
Mrs. Edith A. Davis.
License expires: 9-7-50.

Michigan Hill Nursing Home.
320 S. Michigan Ave., Greensburg.
Mrs. Mary Clifton.
License expires: 12-1-50.

Scripture Nursing Home.
410 S. Broadway, Greensburg.
Mrs. Urba M. Scripture.
License expires: 1-25-51.

DEKALB COUNTY

Brouse Nursing Home.
R. R. No. 2, Butler.
W. H. and Susie M. Brouse.
License expires: 4-28-51.

*Licensed for One Year by the State Department of Public Welfare—List Compiled April 14, 1950

Garrett Convalescent Home.
611 S. Peters St., Garrett.
Mr. and Mrs. Earle Saffen.
License expires: 10-10-50.

Williams Convalescent Home.
402 N. Broadway St., Butler.
R. E. and Pauline Williams.
License expires: 3-23-51.

DELAWARE COUNTY

Arlis R. Clark Nursing Home.
South St., Eaton.
Mrs. Arlis R. Clark.
License expires: 7-29-50.

Karcher Home.
Selma, Ind.
Mrs. Aida Karcher.
License expires: 1-19-51.

Sylvester Home for the Aged.
5 Burlington Drive, Muncie.
Mrs. Nellie V. Sylvester, R.N.
License expires: 7-1-50.

Williams Nursing Home.
1525 S. Monroe St., Muncie.
Mrs. Rena Williams.
License expires: 9-20-50.

Woodland Home.
917 E. Main St., Muncie.
Mrs. Hazel Wilson.
License expires: 8-28-50.

ELKHART COUNTY

The Austin Home.
526 N. 6th St., Goshen.
Mr. and Mrs. Fred S. Austin.
License expires: 12-22-50.

Coil Convalescent Home.
225 S. 5th St., Goshen.
Mrs. Sophia E. Moore.
License expires: 4-3-51.

Holm Convalescent Home.
807 N. Main St., Goshen.
Mrs. Goldie Holm Rogers.
License expires: 4-28-51.

Hope Convalescent Home.
Bristol.
Mrs. Bernice Alverson.
License expires: 8-16-50.

Lockerbie Nursing Home.
302 E. Lincoln Ave., Goshen.
Mrs. Bertha J. K. Lockerbie.
License expires: 7-21-50.

Schieber Convalescent Home.
R. R. No. 2, Bristol.
Mrs. Lulu Schieber.
License expires: 9-29-50.

Cora Shaum Nursing Home.
901 S. 2nd St., Elkhart.
Mrs. Cora Shaum.
License expires: 4-6-51.

Weaver Convalescent Home.
R. R. No. 5, Goshen.
Mrs. Esther Berkey Weaver.
License expires: 1-13-51.

FLOYD COUNTY

Griggs Nursing Home.
710 E. Main St., New Albany.
Mrs. Mary C. Griggs.
License expires: 5-20-50.

FOUNTAIN COUNTY

Maplewood Nursing Home.
R. R. No. 4, Veedersburg.
Mrs. Mable Butte and
Mrs. Maxine Brown.
License expires: 11-15-50.

FRANKLIN COUNTY

Brookside Nursing Home.
R. R. No. 5, Brookville.
Ida Ruth and Chester C. O'Neal.
License expires: 11-30-50.

The Resthaven Reifel Nursing Home.
1015 Franklin St., Brookville.
Mrs. Elizabeth A. Reifel.
License expires: 6-25-50.

FULTON COUNTY

Rochester Nursing Home.
719 Madison St., Rochester.
Ernest Baxter.
License expires: 1-20-51.

GIBSON COUNTY

Church Convalescent Home.
417 W. Broadway, Princeton.
Mrs. Edra E. Church.
License expires: 5-19-50.

GRANT COUNTY

Bide-A-Wee Rest Home.
910 N. Rush St., Fairmount.
Mrs. Agnes Burcher.
License expires: 3-13-31.

Darr's Convalescent Home.
702 E. 26th St., Marion.
Mrs. Maude L. Darr.
License expires: 3-30-51.

Frances' Nursing Home.
1827 S. Adams St., Marion.
Mrs. Frances Moore.
License expires: 6-22-50.

Josephine Hill Nursing Home.
1524 S. Washington St., Marion.
Mrs. Josephine Hill.
License expires: 6-10-50.

Jackson Nursing Home.
R. R. No. 2, Fairmount.
Mrs. Maude J. Jackson.
License expires: 1-27-51.

Mrs. Lanter's Home.
1649 W. Second St., Marion.
Mrs. Anna Lanter.
License expires: 2-17-51.

The Roberts Nursing Home.
P. O. Box 102, Fowlerton.
Mrs. Ethel Roberts.
License expires: 10-14-50.

HAMILTON COUNTY

Arcadia Rest Home.
P. O. Box 215, Arcadia.
Mrs. Florence Sigler.
License expires: 10-24-50.

Moore's Nursing Home.
South St., Arcadia.
Mrs. Anna Moore.
License expires: 12-30-50.

HANCOCK COUNTY

Haney's Nursing Home.
114 E. North St., Greenfield.
Mr. Ila B. Haney.
License expires: 8-10-50.

The Siders Home.
124 E. Osage St., Greenfield.
Mrs. Elizabeth Siders.
License expires: 5-19-50.

Wood's Nursing Home.
14 N. Wood St., Greenfield.
Mrs. Hazel E. Wood.
License expires: 5-19-50.

HENDRICKS COUNTY

Franklin Nursing Home.
Clayton.
Mrs. Sarah E. Franklin.
License expires: 4-29-51.

Plainfield Nursing Home.
404 Vine St., Plainfield.
Miss Lois B. Thompson.
License expires: 1-7-51.

HENRY COUNTY

Homestead (Whitacre Nursing Home).
Spiceland.
Wm. H. and Margaret E. Whiteacre.
License expires: 2-3-51.

HOWARD COUNTY

Colonial Haven Nursing Home.
613 E. Superior St., Kokomo.
Mrs. Edith N. Tolle.
License expires: 10-4-50.

Flossie Coop Nursing Home.
327 S. Union St., Kokomo.
Mrs. Flossie Coop.
License expires: 9-20-50.

Restmor Nursing Home.
420 N. Market St., Kokomo.
Mr. and Mrs. Thomas Devore.
License expires: 5-1-51.

HUNTINGTON COUNTY

Davis Nursing Home.
207 Frederick St., Huntington.
Mrs. Annette Davis.
License expires: 9-23-50.

DeKoning Convalescent Home.
R. R. No. 8, Huntington.
Mrs. Ann Cecilia DeKoning.
License expires: 2-10-51.

Jefferson Sanitarium.
414 S. Jefferson St., Huntington.
Herbert Earl Atkinson, Sr.
License expires: 2-28-51.

Oak Park Nursing Home.
742 N. Main St., Roanoke.
Mrs. Fern N. Martin.
License expires: 6-24-50.

Sears Nursing Home.
325 S. Jefferson, Huntington.
Mrs. Ethel K. Sears.
License expires: 12-15-50.

JACKSON COUNTY

Roselawn Nursing Home.
609 E. 6th St., Seymour.
Mrs. Esta T. Martin.
License expires: 3-24-51.

JEFFERSON COUNTY

Glore Nursing Home.
North Madison.
Mrs. Flora Glore.
License expires: 6-10-50.

Hilltop Rest Home.
Box 67, North Madison.
Mrs. Susan Obertate and
Mrs. Louise Obertate.
License expires: 1-4-51.

Madison Nursing Home.
726 W. Main St., Madison.
Mrs. Ella Shuell, R.N.
License expires: 4-25-51.

JOHNSON COUNTY

Johnson Nursing Home.
651 S. State St., Franklin.
Mrs. Janie Johnson.
License expires: 1-11-51.

McKee's Nursing Home.
400 Kentucky St., Franklin.
Mrs. Florence Ellen McKee.
License expires: 10-6-50.

KOSCIUSKO COUNTY

Alfran Nursing Home.
R. R. No. 1, Road 30, Princeton.
Mrs. Alice M. Wilson, R.N.
License expires: 11-16-50.

Armington Home.
519 W. Winona Ave., Warsaw.
Mrs. Charles Armington.
License expires: 12-8-50.

LAKE COUNTY

Beaton's Nursing Home.
521 Pennsylvania St., Gary.
Mrs. Laura Beaton.
License expires: 4-18-51.

Calloway's Nursing Home*.
1948 Massachusetts St., Gary.
Mrs. Tomye D. Calloway.
License expires: 2-28-51.

Green's Home for Aged.
3960 Massacshusetts St., Gary.
Mrs. Lillian Green.
License expires: 6-29-50.

Hilltop Nursing Home.
R. R. No. 2, Crown Point.
Mrs. Olive Beggs.
License expires: 6-3-50.

Miller's Nursing Home*.
2301 Adams St., Gary.
Miss Ida Miller.
License expires: 4-8-51.

Sanders Nursing Home*.
1944 Maryland St., Gary.
Mrs. LaGora Sanders.
License expires: 5-5-51.

West End Convalescent Home*.
1501 Wheeler St., Gary.
Mrs. Esther G. Jones.
License expires: 6-7-50.

LAWRENCE COUNTY

The Greenwell Home.
329 West Oak Street, Mitchell.
Mrs. Florence Greenwell.
License expires: 8-19-50.

Kinder Nursing Home.
618 "J" Street, Bedford.
Mrs. Mabel M. Kinder.
License expires: 9-27-50.

Stancombe Nursing Home.
R. R. No. 5, Bedford.
Clifford and Pearl Stancombe.
License expires: 4-14-51.

MADISON COUNTY

Bright Memorial Home.
2025 Jackson St., Anderson.
Mrs. Blanche Graser.
License expires: 2-10-51.

Goble Home.
332 W. 11th St., Anderson.
Mr. and Mrs. Oran Goble.
License expires: 7-25-50.

Hughes Nursing Home.
1624 S. "M" St., Elwood.
Mrs. Effie Hughes.
License expires: 1-30-51.

Rahbek Nursing Home No. 1.
1102 E. Sixth St., Anderson.
Mrs. Marie Livingston Rahbek.
License expires: 10-24-50.

Rahbek Nursing Home No. 2.
528 Walnut St., Anderson.
Mrs. Marie Livingston Rahbek.
License expires: 7-30-50.

Rounds Nursing Home.
1312 N. "D" St., Elwood.
Mrs. B. Rounds.
License expires: 2-14-51.

Scott's Nursing Home.
339 Broadway, Pendleton.
Mrs. Donald Scott.
License expires: 9-6-50.

Van Dyke Nursing Home.
2417 Pearl St., Anderson.
Mrs. Pearl M. Van Dyke.
License expires: 3-16-51.

MARION COUNTY

Albrecht's Convalescent Home.
1814 N. New Jersey St.,
Indianapolis.
Mrs. Gertrude Keller Albrecht,
R.N.
License expires: 4-22-50.

Central Nursing Home.
2262 Central Ave., Indianapolis.
Mrs. Bertha A. Montgomery.
License expires: 3-23-51.

Conde Nursing Home.
624 E. 12th St., Indianapolis.
Marian Niles & Beulah Gronlund.
License expires: 11-22-50.

Fletch-Haven Sanitarium.
732 Fletcher Ave., Indianapolis.
Martha L. and Garald Wayne
Starr.
License expires: 6-15-50.

Francis Nursing Home.
604 N. Jefferson Ave.,
Indianapolis.
Mrs. Mattie B. Francis.
License expires: 7-23-50.

Higgins Nursing Home*.
1336 Bellfontaine St.,
Indianapolis.
Mrs. Mollie Higgins.
License expires: 2-17-51.

Hillside Nursing Home*.
2370 Hillside Ave., Indianapolis.
Henry and Ellen Mangulm.
License expires: 11-15-50.

Huff Sanitarium.
115 S. Audubon Road,
Indianapolis.
Mrs. Rachel A. and Bettina
Sullivan.
License expires: 8-9-50.

Hulst Sanatorium.
331-333 N. Delaware St.,
Indianapolis.
Mrs. Mary E. Hulst.
License expires: 6-28-50.

Irvington Sanitarium.
R. R. No. 10, Box 320,
Indianapolis.
Mrs. Minnie P. Waymire.
License expires: 7-7-50.

Jennings Rest Home.
942 N. Alabama St., Indianapolis.
Mrs. Etta B. Jennings.
License expires: 11-28-50.

King Nursing Home.
1907 N. Illinois St., Indianapolis.
Mrs. Henrietta Princie King
Quinn.
License expires: 11-30-50.

Myrtle Lee Nursing Home.
1429 Carrollton Ave., Indianapolis.
Miss Mabel Cecilia Smalley.
License expires: 5-16-50.

The Lou Wise.
5170 W. Washington St., Indianapolis.
Mrs. Bessie Craig.
License expires: 2-9-51.

Lucile Nursing Home.
610 N. Senate Ave., Indianapolis.
Mrs. Lucile Mealure.
License expires: 5-1-51.

Lynhurst Nursing Home No. 1.
5225 W. Morris St., Indianapolis.
Thomas E. and Barbaraella K. Brown.
License expires: 4-10-51.

Martin Nursing Home.
2037 N. Illinois St., Indianapolis.
Mrs. Beulah Martin.
License expires: 3-8-51.

Matthews Rest Home.
823 Broadway, Indianapolis.
Mrs. Ethel M. Matthews.
License expires: 3-31-51.

Maxson Nursing Home.
842 Broadway, Indianapolis.
Mrs. Helen Maxson.
License expires: 9-20-50.

Mary Messer Nursing Home.
1336 N. Delaware St., Indianapolis.
Mrs. Mary J. Messer.
License expires: 11-26-50.

Mohler Sanatorium.
702-704 N. Alabama St., Indianapolis.
Mrs. Ada Anselm Mohler.
License expires: 3-11-51.

Olympia Nursing Home.
6879 E. Washington St., Indianapolis.
Mrs. Frances Limpus.
License expires: 8-8-50.

Pleasant View Rest Home.
5000 Southeastern Ave., Indianapolis.
Mrs. Laura E. Weber.
License expires: 2-9-51.

Rest Haven Sanitarium.
3245 N. Illinois St., Indianapolis.
Mrs. Carolyn E. Carden.
License expires: 6-9-50.

Robinson's Private Home No. 1.
2254 Central Ave., Indianapolis.
Mrs. Eunice C. Robinson.
License expires: 7-14-50.

Robinson's Private Home No. 2.
2250 Central Ave., Indianapolis.
Mrs. Eunice C. Robinson.
License expires: 7-14-50.

The Roethig Home.
350 Villa Ave., Indianapolis.
Mrs. Anna Roethig.
License expires: 6-3-50.

Rose Lawn Home.
2835 N. Meridian St., Indianapolis.
Mrs. Lucy V. Conner.
License expires: 5-5-51.

Suddarth Nursing Home.
1445 Broadway St., Indianapolis.
Mrs. Cleo Suddarth.
License expires: 5-28-50.

Sunshine Nursing Home.
4416 E. Washington St., Indianapolis.
Mrs. Ethel M. Bills.
License expires: 2-17-51.

Tall Cedars.
R. R. No. 1, Box 27, Bridgeport.
Mrs. Ora Miley.
License expires: 4-18-51.

Vollmer Convalescent Home.
2630 College Ave., Indianapolis.
Mr. Emory H. Vollmer.
License expires: 6-24-50.

Mrs. Waddle's Private Home.
2112 N. Delaware St., Indianapolis.
Mrs. Mable S. Waddle.
License expires: 8-29-50.

Ward Nursing Home*.
1518 N. Senate Ave., Indianapolis.
Mrs. Willa Mae Murray Anderson.
License expires: 5-19-50.

Warman Rest Home.
46 S. Warman Ave., Indianapolis.
Mr. Bertrand D. Frame.
License expires: 1-6-51.

Weber Convalescing Home.
43 S. Ritter Ave., Indianapolis.
Mrs. Laura E. Weber.
License expires: 4-24-51.

West Park Home.
373 N. Holmes Ave., Indianapolis.
Mrs. Mary R. Frame.
License expires: 6-18-50.

Wildwood Restorium.
895 Middle Drive, Woodruff Place, Indianapolis.
Mrs. Nellie Wildman.
License expires: 5-5-51.

MARSHALL COUNTY

Austin Nursing Home.
821 Angel St., Plymouth.
Mrs. Mabel M. Austin.
License expires: 9-23-50.

Bair Convalescent Home.
N. Main St., Bourbon.
Mrs. Kathryn M. Bair, R.N.
License expires: 8-8-50.

Pearl Street Nursing Home.
618 Pearl St., Plymouth.
Miss Bertha Mohr and Mrs. Grace Stonehill.
License expires: 7-21-50.

Sally's Nursing Home.
917 N. Walnut St., Plymouth.
Mrs. Sally Kaufman.
License expires: 7-22-50.

Sherman Nursing Home.
203 Pennsylvania Ave., Plymouth.
Mrs. Vesta K. Sherman.
License expires: 10-18-50.

MIAMI COUNTY

Glen Rest Convalescent Home.
R. R. No. 4, Peru.
Mrs. Thelma Woeckener.
License expires: 6-30-50.

Peru Nursing Home No. 1.
906 W. Main St., Peru.
Mrs. Marie A. Donat.
License expires: 3-11-51.

Peru Nursing Home No. 2.
27 E. Third St., Peru.
Mrs. Marie A. Donat.
License expires: 12-12-50.

MONROE COUNTY

Hazel's Nursing Home.
1031 W. 6th St., Bloomington.
Mr. William S. Hazel.
License expires: 11-26-50.

Henry Home.
421 W. 1st St., Bloomington.
Mrs. Gertie Henry.
License expires: 2-11-51.

Parrott Nursing Home.
115 S. Lincoln St., Bloomington.
Mary Gwendolia Parrott, R.N.
License expires: 7-21-50.

Polley Nursing Home.
705 W. 4th St., Bloomington.
Mrs. Elsie Mae Polley.
License expires: 12-5-50.

Wilkins Nursing Home No. 1.
1023 E. 10th St., Bloomington.
Mrs. Orpha A. Wilkins.
License expires: 3-29-51.

Wilkins Nursing Home No. 2.
601 N. Walnut Grove, Bloomington.
Mrs. Orpha A. Wilkins.
License expires: 3-29-51.

MONTGOMERY COUNTY

Hart Memorial Home.
R. R. No. 1, Crawfordsville.
Mrs. Myrtle Johnson.
License expires: 4-14-51.

Maxwell Nursing Home.
1805 E. Fremont St.,
Crawfordsville.
Mrs. Godey Maxwell Graves.
License expires: 8-25-50.

Hazel Small's Rest Home.
North Vine St., Waynetown.
Mrs. Hazel Small.
License expires: 3-24-51.

OHIO COUNTY

Galbreath Home.
Fourth St., Rising Sun.
Mrs. Effie Galbreath.
License expires: 3-31-51.

OWEN COUNTY

Gosport Nursing Home.
West Main St., Gosport.
Mrs. Annis T. Martin.
License expires: 7-5-50.

Reapp Nursing Home.
Spencer.
Mrs. Jennie C. Reapp.
License expires: 7-26-50.

PARKE COUNTY

Wallace Nursing Home.
517 W. Ohio St., Rockville.
Mrs. Evelyn Wallace.
License expires: 7-18-50.

PIKE COUNTY

Fay's Convalescent Home.
210 S. 14th St., Petersburg.
Mrs. Fay France.
License expires: 5-26-50.

Moore's Nursing Home.
409 W. Walnut St., Petersburg.
Mrs. Adaline Bernice Moore.
License expires: 5-24-50.

Riddle Nursing Home.
411 Walnut St., Petersburg.
Mrs. Alice M. Riddle.
License expires: 4-10-51.

PORTER COUNTY

Wood Nursing Home.
R. R. No. 2, West Dunes
Highway.
Michigan City.
Mrs. Helen O. Wood.
License expires: 6-12-50.

POSEY COUNTY

Allison Nursing Home.
Poseyville.
Mrs. Lula Allison.
License expires: 11-15-50.

PUTNAM COUNTY

Ruark Nursing Home.
R. R. No. 1, Fillmore.
Mrs. Elsie Cowgill Ruark.
License expires: 9-9-50.

Westfall Nursing Home.
218 Bloomington St., Greencastle.
Mrs. Nina A. Westfall.
License expires: 11-26-50.

RIPLEY COUNTY

Elsie Dreyer Nursing Home.
Sunman.
Miss Elsie Dreyer.
License expires: 10-5-50.

RUSH COUNTY

Clark Boarding & Nursing Home.
230 E. 7th St., Rushville.
Mr. and Mrs. Harry Clark.
License expires: 1-20-51.

Clifton Nursing Home No. 1.
204 W. 3rd St., Rushville.
Mrs. Mary Clifton.
License expires: 9-29-50.

Jackson Nursing Home.
413 N. Morgan St., Rushville.
Mrs. Goldie C. Jackson.
License expires: 12-8-50.

Rushville Nursing Home.
321 N. Morgan St., Rushville.
Mr. Jack Fordyce.
License expires: 1-11-51.

SHELBY COUNTY

Land's Nursing Home.
Morristown.
Ida and Elbert Land.
License expires: 10-25-50.
(Provisional License.)

Maples Convalescent Home, Inc.
R. R. No. 1, Fountaintown.
Mr. and Mrs. William McGraw.
License expires: 11-16-50.

SPENCER COUNTY

Mayhall Nursing Home.
417 S. 6th St., Rockport.
Mrs. Alice R. Mayhall Freshley.
License expires: 11-16-50.

ST. JOSEPH COUNTY

Branchflower Nursing Home.
1217 S. Michigan St., South Bend.
Mrs. Maggie R. Branchflower.
License expires: 7-21-50.

Copenhaver Home.
914 W. 4th St., Mishawaka.
Mrs. June Copenhaver.
License expires: 4-29-51.

Elderly Folks Home.
P. O. Box 51, Lakeville.
Mrs. Louise Clements.
License expires: 7-13-50.

Emerick Home for the Aged.
910 W. 4th St., Mishawaka.
Mrs. Ila Mae Emerick.
License expires: 9-12-50.

Frame's Nursing Home.
1526 Lincoln Way, West,
South Bend.
Mrs. Myrtle Frame.
License expires: 8-3-50.

Vera Jones Nursing Home.
702 S. Columbia St., South Bend.
Mrs. Vera Jones.
License expires: 12-5-50.

Kintz's Rest Home.
1527 S. Bend Ave., South Bend.
Mrs. Edith Kintz.
License expires: 11-2-50.

Krogh Nursing Home.
109 N. Cedar St., Mishawaka.
Miss Bernalda I. Krogh.
License expires: 4-29-51.

Waldron Nursing Home.
500 Roosevelt Rd., Walkerton.
Mrs. Virginia Waldron.
License expires: 8-8-50.

Williams Nursing Home No. 1.
601 N. Main St., South Bend.
Mrs. Alma Williams.
License expires: 7-13-50.

Williams Nursing Home No. 2.
1145 Napier St., South Bend.
Mrs. Alma Williams.
License expires: 11-17-50.

STEUBEN COUNTY

Edith Nursing Home.
116 Powers St., Angola.
Mrs. Edith Shmidt.
License expires: 12-7-50.

TIPPECANOE COUNTY

Laura M. Bowles Convalescent Home.
Clarks Hill.
Mrs. Laura M. Bowles.
License expires: 4-20-51.

Burnett's.
221 S. 9th St., Lafayette.
Mrs. Angie Burnett.
License expires: 4-4-51.

Lewis Nursing Home.
641 New York St., Lafayette.
Mrs. Betty Mackey Lewis.
License expires: 1-10-51.

Scott Nursing Home for Men.
614 N. 8th St., Lafayette.
Mr. Howard F. Scott.
License expires: 8-9-50.

Scott Nursing Home for Women.
1100 N. 9th St., Lafayette.
Mrs. Goldie Scott.
License expires: 12-10-50.

UNION COUNTY

Scott Nursing Home.
302 W. Union St., Liberty.
Mrs. Anna Scott.
License expires: 5-12-50.

VANDERBURGH COUNTY

Bethany Rest Home.
316 N. Wabash Ave., Evansville.
Mrs. Edith Poole Masterson.
License expires: 5-18-50.

Comfort Rest Home.
811 Southeast 3rd St., Evansville.
Mrs. Ethel B. Drake.
License expires: 10-14-50.

Anna Evans Nursing Home*.
605 Oak St., Evansville.
Mrs. Anna Evans.
License expires: 3-24-51.

Gee's Rest Haven.
807 Southeast 3rd St., Evansville.
Mrs. Leona Gee.
License expires: 2-14-51.

Gish's Rest Home.
923 S. Elliott St., Evansville.
Mrs. Ethel G. Gish.
License expires: 11-30-50.

Heffington Nursing Home.
619 Southeast 1st St., Evansville.
Mrs. Flora B. Heffington.
License expires: 8-10-50.

Jarrett's Convalescent Home.
605 Oakley St., Evansville.
Mrs. Lena K. Jarrett.
License expires: 6-30-50.

M. & R. Nursing Home.
1100 N. Read St., Evansville.
Mrs. Muriel A. Beumer.
License expires: 8-10-50.

The Maxey Nursing Home.
36 W. Illinois St., Evansville.
Mr. and Mrs. Pearless Maxey.
License expires: 8-25-50.

Pickett & Floyd Boarding Home.
200-202 W. Illinois St., Evansville.
Wm. J. Pickett and Laura Floyd.
License expires: 11-16-50.

Pleasant Nursing Home.
109 W. Maryland St., Evansville.
Mrs. Maryetta Morris.
License expires: 7-5-50.

Singleton Nursing Home.
909 First Ave., Evansville.
Mrs. Fern Singleton.
License expires: 6-2-50.

Ingle Smith Home.
521 Southeast 1st St., Evansville.
Mrs. Della Ingle Smith, R.N.
License expires: 6-25-50.

Stinson Rest Home.
315 Southeast 2nd St., Evansville.
Mrs. Mildred Stinson.
License expires: 11-14-50.

Taylor Nursing Home.
915 W. Bond St., Evansville.
Mrs. Juanita Taylor.
License expires: 8-9-50.

Tindall Rest Home.
216-218 Harriett St., Evansville.
Mrs. Dorothy Wolf Tindall.
License expires: 1-31-51.

Ulbricht Rest Home.
616 W. Franklin St., Evansville.
Mrs. Martha Ulbricht.
License expires: 3-10-51.

VIGO COUNTY

Cook Nursing Home.
2058 N. 7th St., Terre Haute.
Mrs. Grace E. Cook.
License expires: 7-21-50.

Foos Nursing Home.
418 S. 8th St., Terre Haute.
Mrs. Lydia E. Foos.
License expires: 7-21-50.

Gano Nursing Home.
501 N. 4th St., Terre Haute.
Mrs. Anna Gano.
License expires: 4-8-51.

Hise Nursing Home.
120 N. 12th St., Terre Haute.
Mrs. Lillie Hise.
License expires: 3-21-51.

Kesler's Nursing Home.
724 N. 8th St., Terre Haute.
Mrs. Clara A. Kesler.
License expires: 8-19-50.

Myrtle Rollo Nursing Home.
635 N. 6th St., Terre Haute.
Mrs. Myrtle Rollo.
License expires: 6-17-50.

Doris Standeford Nursing Home.
1103 South 11½ St., Terre Haute.
Miss Doris Standeford.
License expires: 3-16-51.

Meda Stevenson Home,
905 Crawford St., Terre Haute.
Mrs. Meda Stevenson.
License expires: 7-5-50.

Sullivan Nursing Home.
705 S. 7th St., Terre Haute.
Mrs. Grace F. Sullivan.
License expires: 12-30-50.

WABASH COUNTY

Moss Nursing Home.
855 Ferry St., Wabash.
Mrs. Irene Moss.
License expires: 8-27-50.

Sincroft Nursing Home.
306 E. 4th St., North Manchester.
Mrs. Pearl Sincroft.
License expires: 1-21-51.

WASHINGTON COUNTY

Shuell Nursing Home No. 1
R. R. No. 1, Scottsburg.
Mrs. Ella L. Shuell, R.N.
License expires: 5-7-50.

Shuell Nursing Home No. 2.
R. R. No. 1, Scottsburg.
Mrs. Ella L. Shuell, R.N.
License expires: 5-7-50.

WAYNE COUNTY

Bowman's Rest Home.
444 W. Main St., Cambridge City.
Howard and Esther Bowman.
License expires: 3-16-51.

Gains Nursing Home No. 1.
R. R. No. 2, Box 448, Richmond.
Mrs. Emma Gains.
License expires: 1-5-51.

Gains Nursing Home No. 2.
R. R. No. 2, Richmond.
Mrs. Emma Gains.
License expires: 1-3-51.

Grey Gables Nursing Home.
R. R. No. 1, Centerville.
Mrs. Hazel C. Wadie.
License expires: 8-10-50.

Pinehurst Nursing Home.
R. R. No. 2, Centerville.
Mrs. Gertrude E. Johnson.
License expires: 7-5-50.

WELLS COUNTY

Davis Nursing Home.
R. R. No. 3, Bluffton.
Mrs. Helen Davis.
License expires: 6-10-50.

WHITLEY COUNTY

Farris Nursing Home.
209 W. Market St., Columbia City.
Mrs. Louise Farris.
License expires: 1-11-51.

South Whitley Rest Home, Inc.
Columbia St., South Whitley.
Mr. and Mrs. Robert E.
Bresnahan and Grace Beaman.
License expires: 1-27-51.

* These homes will accept colored patients.

PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION‡

"These principles are not laws to govern but are principles to guide to correct conduct." (James Percival's Principles of Ethics 1803.)

CHAPTER I

General Principles

CHARACTER OF THE PHYSICIAN

Section 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

THE PHYSICIAN'S RESPONSIBILITY

Sec. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."*

GROUPS AND CLINICS

Sec. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

ADVERTISING

Sec. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

EDUCATIONAL INFORMATION NOT ADVERTISING

Sec. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

PATENTS, COMMISSIONS, REBATES AND SECRET REMEDIES

Sec. 6.—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

EVASION OF LEGAL RESTRICTIONS

Sec. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

CHAPTER II

Duties of Physicians to Their Patients

STANDARDS, USEFULNESS, NONSECTARIANISM

Section 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is

‡ Adopted by the American Medical Association House of Delegates on June 6, 1949.

* Sir Thomas Watson.

* Nicon, father of Galen.

a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

CHAPTER III

DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLDING THE HONOR OF THE PROFESSION

SECTION 1.—A physician is expected to uphold the dignity and honor of his vocation.

MEMBERSHIP IN MEDICAL SOCIETIES

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

SAFEGUARDING THE PROFESSION

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

DEPENDENCE OF PHYSICIANS ON EACH OTHER

SECTION 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN IN CHARGE

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

ARTICLE III.—DUTIES OF PHYSICIANS IN CONSULTATIONS

CONSULTATIONS SHOULD BE ENCOURAGED

SECTION 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

SEC. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

PUNCTUALITY

SEC. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO CONSULTANT

SEC. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

DISCUSSIONS IN CONSULTATION

SEC. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made, nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

RESPONSIBILITY OF ATTENDING PHYSICIAN

SEC. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is

privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

CONFLICT OF OPINION

SEC. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SECTION 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENT OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the phyisician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DISPUTES BETWEEN PHYSICIANS

ARBITRATION

SECTION 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promplty adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SECTON 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

FREE CHOICE OF PHYSICIAN

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether

the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

CHAPTER IV

THE DUTIES OF PHYSICIANS TO THE PUBLIC

PHYSICIANS AS CITIZENS

SECTION 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

CONCLUSION

These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles.

CONSTITUTION AND BY-LAWS OF THE INDIANA STATE MEDICAL ASSOCIATION*

CONSTITUTION

ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

ARTICLE II.—PURPOSES OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

Section 1.—This Association shall consist of Active Members, Associate Members, Senior Members and Honorary Members.

Sec. 2.—*Active Members.*—The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant membership therein on a basis that does not include membership in the Indiana State Medical Association.

Sec. 3.—*Associate Members.*—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

Sec. 4—*Senior Members.*—Senior members shall be physicians of the State of Indiana who have attained the age of seventy-five years and have held membership in the Indiana State Medical Association for twenty years or more, and who, upon their application, have been certified to the executive secretary as eligible for such membership by the county societies of which they are members.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above

* Adopted by the House of Delegates at Indianapolis, September 29, 1949.

qualifications, shall hereafter be classified as senior members.

Sec. 5.—*Honorary Members.*—Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Sec. 6.—*Rights and Privileges of Members.*—Active members and senior members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

c. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold office. They shall not be required to pay membership dues in the State Association.

ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be *ex-officio* members: the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

ARTICLE VI.—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, and Treasurer. Besides its duties mentioned in the By-Laws, it shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the By-Laws, and at all times shall be the finance committee of the Association. Seven Councilors shall constitute a quorum.

ARTICLE VII.—SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Councilor districts shall be defined by the House of Delegates.

ARTICLE VIII.—CONVENTION AND MEETINGS

Section 1.—The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Sec. 2.—The House of Delegates shall select the place two years in advance for holding the annual convention. The time for the convention shall be fixed by the Council, and the Council shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Sec. 3.—Special meetings of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members.

ARTICLE IX.—OFFICERS

Section 1.—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

Sec. 2.—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. All of these officers shall serve until their successors are elected and installed. Provided, that if any elected Councilor fails, without reason acceptable to the Council, in any one calendar year to attend a majority of the meetings of the Council, he shall thereby cease to be a Councilor, and the Executive Secretary shall thereupon take action in accordance with Section 4 of this article.

Sec. 3.—The officers of this Association with the exception of the Executive Secretary shall be elected by the House of Delegates as the first order of business of the last day of the Annual Convention, and no person shall be elected to any such office who is not in attendance on that Annual Convention and who has not been a member of the Association for the preceding two years.

Sec. 4.—The Councilors shall be elected by the respective district societies. If any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Sec. 5.—Each Councilor district shall elect an alternate Councilor whose term of office shall be the same as the Councilor, namely three years. The alternate Councilor shall be elected in a year during which there is no Councilor elected.

The duties of the alternate Councilor shall be:

1. To represent the Councilor district in the absence of the regularly elected Councilor.

2. To vote only in the absence of the regularly elected Councilor either in the House of Delegates or in Council meetings where he represents the regularly elected Councilor.

3. The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present.

Sec. 6.—Any officer may be removed from office after a hearing before the Council, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Council.

Sec. 7.—In event of the death, resignation, removal, or disability of the President, the President-elect shall succeed to the presidency. In the event of the death, disability, resignation or removal of both the President and the President-elect, the chairman of the Council shall become President pro tem and as such shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-elect shall be elected, both of whom shall take office immediately upon their election.

Sec. 8.—A vacancy in the office of Treasurer shall be filled by an election by the Councilors at the next regular meeting of the Council following the occurrence of such vacancy.

Sec. 9.—None of the officers shall receive compensation except the Executive Secretary, who shall be employed by the Council, and the Council shall fill any vacancy in that office.

ARTICLE X.—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

ARTICLE XI.—INCOME AND EXPENSES

Funds for carrying on the activities of this Association shall be raised by the following means:

a. Membership dues to be collected by the component county societies in connection with the dues for such component societies. The amount of the dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

b. Voluntary contributions.

c. Revenues derived from the Association's publications.

d. Any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.

ARTICLE XII.—REFERENDUM

Section 1.—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all the members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2.—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII.—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XIV.—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association.

BY-LAWS

CHAPTER 1.—MEMBERSHIP

Section 1.—The term "Member" as used in these By-Laws unless otherwise indicated shall mean both active and senior members.

Sec. 2.—Any physician who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association.

Sec. 3.—No person who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Sec. 4.—Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

CHAPTER II.—GENERAL MEETINGS

Section 1.—General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President shall be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Committee on Scientific Work, with the sanction and approval of the officers.

Sec. 2.—The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Sec. 3.—All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Secretary when read.

Sec. 4.—The Council shall appropriate from the funds of the Association for each Annual Convention, for the entertainment of its members and guests, such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such convention. The entertainment funds so appropriated shall be expended at the direction of the Committee on Convention Arrangements, appointed by the President for the convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the State Association.

CHAPTER III.—SECTIONS

Section 1.—During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

a. Surgical.

b. Medical.

c. Eye, Ear, Nose, and Throat.

d. Anesthesia.

e. General Practice.

f. Obstetrics and Gynecology.

g. Any other sections that hereafter may be provided for by the House of Delegates.

Sec. 2.—The officers of each section shall be a Chairman, a Vice-Chairman, and a Secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Sec. 3.—The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Sec. 4.—No section meeting shall be allowed to conflict with a general meeting.

CHAPTER IV.—HOUSE OF DELEGATES

Section 1.—The House of Delegates shall meet the day before or during that fixed as the first day of the scientific meeting of the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General or Section Meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program.

Sec. 2.—Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and By-Laws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate to be selected by the physicians residing in such county.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association annually on or before August first prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credentials as a delegate or alternate, properly signed by the secretary of his county society, be presented to the Committee on Credentials at the time of the Annual Convention.

Sec. 3.—Fifty delegates shall constitute a quorum.

Sec. 4.—The House of Delegates shall:

a. Elect representatives to the House of Delegates of the American Medical Association in

accordance with the Constitution and By-Laws of that body.

b. Divide the State into Councilor Districts, specifiying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

c. Have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

d. Approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 5. — Funds may be appropriated by the House of Delegates, subject to approval by the Council, for such purposes as will promote the welfare of the Association and the profession.

Sec. 6.—At the first meeting the President shall announce the membership of the reference committees, as hereinafter provided for, and any other committees considered by him necessary to expedite the business of the Association.

CHAPTER V.—ELECTION OF OFFICERS

Section 1.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

Sec. 2.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Sec. 3.—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years.

Sec. 4.—The President, President-elect, and the Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect and Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

CHAPTER VI.—DUTIES OF OFFICERS

Section 1.—The President, or a member designated by him, shall preside at all general meetings of the Association and of the House of Delegates. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2.—The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties.

Sec. 3.—The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Council. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the Chairman of the Council. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

Sec. 4.—The Executive Secretary shall be the directing manager of the Association's headquarters and Journal offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Council, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.

Sec. 5.—The necessary expenses of the above officers incurred in the line of duty herein imposed may be allowed by the Council, but excepting the Executive Secretary, this shall not include the expense of attending the Annual Convention.

CHAPTER VII.—COUNCIL

Section. 1.—The Council shall meet as follows: 1. January, April, and July of each year on dates

and at places fixed by the Council. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the Chairman, or on petition of three Councilors. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a Chairman, and a Clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates.

Sec. 2. — Each Councilor shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the Council on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

Sec. 3.—The Council shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

Sec. 4.—The Council shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Sec. 5.—The Council shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Sec. 6.—The Council shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 7.—The Council shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and By-Laws.

Sec. 8.—In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 9.—The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Sec. 10.—The Council shall provide for and superintend all publications of the Association, and shall have authority to appoint an editor and such assistants as it deems necessary, and fix the amounts of their salaries. The proceedings of the Council for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediately precedes the Annual Convention.

Sec. 11.—In the interim between the meetings of this Association the Council shall be the executive body of the Association with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require.

Sec. 12.—The Council shall elect two members of the Association, who, with the President, the President-elect, the Treasurer, and the Chairman of the Council, shall constitute and be known as the Executive Committee.

CHAPTER VIII.—STANDING COMMITTEES

Section 1.—The standing committees shall be as follows:

The Executive Committee.

A Committee on Convention Arrangements.

A Committee on Scientific Work.
A Committee on Scientific Exhibits.
A Committee on Public Policy and Legislation.
A Committee on Publicity.
A Committee on Industrial Health.
A Committee on Medical Education and Hospitals.
A Committee on Public Relations.
A Committee on Constitution and By-Laws.

Such committees, except the Executive Committee, which is elected by the Council, shall be appointed by the President of the Association.

All members of committees shall serve for one year unless otherwise specified in these By-Laws or in the authorization for appointment.

Sec. 2.—*The Executive Committee*, consisting of six members as heretofore provided for, shall meet on the call of the Chairman or of any three members with the Executive Secretary to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office. It shall constitute the Medical Defense Committee of the Association and shall have full authority governing all matters pertaining to the medical defense features of this Association, and shall be governed by the rules and regulations concerning such features as provided for in the By-Laws of this Association. It shall represent the Council during the intervals between meetings of that body, including matters pertaining to THE JOURNAL of the Association, and shall report its doings to the Council.

It shall prepare a budget for the ensuing calendar year; and all expenditures of the Association, except those otherwise provided for under the Constitution and By-Laws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and By-Laws shall be incurred by any officer or committee. A committee or an officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

Sec. 3.—*The Committee on Convention Arrangements* shall consist of five or more members. With the advice and assistance of the Executive Secretary this committee shall provide suitable accommodations for the meetings of the Association, including the House of Delegates, Council, and of their respective committees, the scientific and technical exhibits, and in conjunction with the Executive Secretary shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Executive Secretary of the Association for publication in THE JOURNAL and in the official program, and shall make additional announcements during the session as occasion may require. The arrangements for and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

Sec. 4.—*The Committee on Scientific Work* shall consist of three or more appointive members appointed by the President; and of the chairman of the Committee on Scientific Exhibits and of the chairmen of the sections as *ex officio* members. It shall be the duty of the officers of the various sections to prepare and submit to this committee prior to the first meeting of the committee a suggested program of subjects and personnel for their respective section programs for the Annual Convention. The scientific program and the financial requirements to provide for it must be approved by the Executive Committee before the program is officially announced.

Sec. 5.—*The Committee on Scientific Exhibits* shall consist of five or more appointive members. It shall have the duty of arranging for scientific exhibits as a part of the Annual Convention, subject to the approval of the Executive Committee.

Sec. 6.—*The Committee on Public Policy and Legislation* shall consist of at least five or more appointive members. Under direction of the House of Delegates it shall represent the Association in securing and enforcing legislation in the interest of public health, medical education, scientific medicine, and the improvement of the medical profession. It shall keep in touch with professional and public opinion and shall endeavor to create and direct public opinion to the end that the public will demand adequate legislation for the promotion of the public good in relation to medicine and the enforcement of such legislation.

Sec. 7.—*The Committee on Publicity* shall consist of three appointive members. It shall be responsible for the dissemination of information concerning individual and community health to the lay public through articles prepared for publication in lay publications, and for addresses or talks delivered before lay audiences under the authority of the Association, and shall in every way seek to give the lay public a better knowledge and understanding of the aims and objects of scientific medicine.

Sec. 8.—*The Committee on Industrial Health* shall consist of five or more appointive members. The duties of the committee shall be: To study and gather facts and become intimately acquainted with the problems regarding industrial health, including any such problems as those relating to the prevention and cure of industrial injuries and diseases; to study the method and means of providing adequate medical and hospital care for those suffering from industrial diseases and injuries; and to encourage cooperation and mutual understanding among the members of the medical profession, employers of labor, employees and insurance carriers.

Sec. 9.—*The Committee on Medical Education and Hospitals* shall consist of five appointive members. The duties of this committee shall be

to cooperate with the authorities of the Indiana University School of Medicine in efforts to improve the educational standards of the state as they pertain to the practice of medicine; to act in conjunction with the members of the Council in providing postgraduate clinics or teaching for the various Councilor medical districts of the state; to cooperate with the Hospital Council of the Indiana State Board of Health in connection with the making and recommending of rules and regulations for the management of hospitals; to select one of its own members as a delegate to the yearly Conference on Medical Education and Hospitals of the American Medical Association; and to cooperate with the corresponding Council of the American Medical Association.

Sec. 10.—*The Committee on Public Relations* shall consist of five or more appointive members. The duties of the committee shall be to develop and carry on continuously a program to improve and sustain good will among the members of the medical profession and the general public; to study and assemble information regarding the means by which the interests of the public relations of the medical profession may best be served; to obtain through public and professional contacts and report to the profession through proper means information regarding the sentiments, criticism and suggestions for improvement which may be made either by members of the profession or by the lay public; and to have the special responsibility of furnishing leadership and guidance in keeping the medical profession as a whole within the deserved respect and esteem of the people.

Sec. 11.—*The Committee on Constitution and By-Laws* shall consist of five appointive members. The duties of this committee shall be: to keep in contact with the developments and changes in procedures in carrying on the work of this Association; to suggest revisions necessary to keep the Constitution and By-Laws always in accord with the practices and procedures best adapted to the functioning of the Association; and to keep the practices and procedures consistent with the provisions from time to time contained in the Constitution and By-Laws—to the end that all members of the profession, by reference to the Constitution and By-Laws, may be able to obtain accurate information regarding procedure and practices within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and By-Laws may be avoided.

Sec. 12.—The President and Executive Secretary shall be *ex officio* members of all the foregoing standing Committees where their inclusion on the committee is not otherwise provided for in these By-Laws.

CHAPTER IX.—SPECIAL COMMITTEES

The President may appoint such other committees in addition to the standing committees as he deems necessary or as may be specially authorized by the House of Delegates, the Council, or the Executive Committee. Any such committees shall be known as special committees.

CHAPTER X.—REFERENCE COMMITTEES

Section 1.—Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the President in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention.

The President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of five members, the chairman to be specified by the President. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

Sec. 2.—The following reference committees are hereby constituted:

(1) A Committee on Sections and Section Work to which shall be referred all matters relating to the sections or section work.

(2) A Committee on Rules and Order of Business to which shall be referred all matters regarding rules governing the action, methods of procedure, and order of business of the House of Delegates.

(3) A Committee on Medical Education and Hospitals to which shall be referred all matters relating to medical education and medical colleges and hospitals.

(4) A Committee on Public Policy and Legislation to which shall be referred all matters relating to state and national legislation, and memorials to the legislature, to the United States Congress, to the Governor of the State, or to the President of the United States.

(5) A Committee on Publicity to which shall be referred all matters relating to publicity.

(6) A Committee on Hygiene and Public Health to which shall be referred all matters relating to hygiene and public health.

(7) A Committee on Amendments to the Constitution and By-Laws to which shall be referred all proposed amendments to the Constitution and By-Laws.

(8) A Committee on Reports of Officers to which shall be referred the address of the President and the reports of the Executive Secretary, Treasurer, and the Council.

(9) A Committee on Credentials to which shall be referred all questions regarding registration and the credentials of delegates.

(10) A Committee on Miscellaneous Business to which shall be referred all business not otherwise disposed of.

Sec. 3.—The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

CHAPTER XI.—COUNTY SOCIETIES

Section 1.—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, on application, receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and By-Laws and other rules and resolutions of this Association.

Sec. 2.—Charters shall be issued only upon approval of the Council and shall be signed by the President and Executive Secretary of this Association. The Council shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

Sec. 3.—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 4.—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Sec. 5.—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

Sec. 6.—In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 7.—When a member in good standing in a component society moves to another county in this state his name, on request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the membership is proposed.

Sec. 8.—A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice.

Sec. 9.—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Sec. 10.—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before August first.

Sec. 11.—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Councilor of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Councilor shall also be sent to the Executive Secretary of

the State Association. The State Association shall supply each county secretary a form for these reports.

Sec. 12.—The fiscal year of the Association shall be the calendar year, and all dues shall be for the year and *payable in advance.* The secretary of each component society shall forward the dues for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Secretary of this Association the dues for such new members. The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only. Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay $10.00 as dues for the remainder of that year. Interns and residents shall pay $10.00 a year annual dues during their term of service in the hospital.

Sec. 13.—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 14.—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Sec. 15.—Each component society shall have its own Constitution and By-Laws, not in conflict with the Constitution and By-Laws either of this Association or of the American Medical Association, a copy of which shall be filed with the Executive Secretary of this Association; and furthermore, the Executive Secretary shall be notified at once of any changes or amendments that may be made from time to time.

CHAPTER XII.—MISCELLANEOUS

Section 1.—The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and By-Laws.

Sec. 2.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

CHAPTER XIII.—MEDICAL DEFENSE

Section 1.—One dollar and twenty-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Sec. 2.—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Sec. 3.—This committee shall have full authority governing all matters pertaining to the medical defense features of this Association; with power to enter into agreement for the payment of fees of one attorney whom the physician sued shall have the right to choose, provided such attorney is of good reputation and standing at the bar, and to employ expert witnesses and incur such other expenses as in the judgment of the committee may be necessary in the defense of members against whom suits may be brought; provided, always, that the total expenditure in any single suit shall not exceed 25 per cent of the fund available at the time suit is filed; and provided further that this Association shall not be liable for attorney's fees in such suits unless this committee shall have first agreed in each case with the physician sued and the attorneys representing him in regard to the terms of such employment, including the fees to be paid.

Sec. 4.—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the Chairman of the Council.

Sec. 5.—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Sec. 6.—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these By-Laws.

Sec. 7.—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become de-

linquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.

Sec. 8.—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive Secretary of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the President, Secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Sec. 9.—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Sec. 10.—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Sec. 11.—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Sec. 12.—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Sec. 13.—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Sec. 14.—Medical defense as provided for by this Association shall be available to members under the terms stated in these By-Laws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

CHAPTER XIV.—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XV.—AMENDMENTS

Section 1.—These By-Laws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and By-Laws all previous Constitutions and By-Laws are hereby repealed.

Again at the 101st Convention of the Indiana State Medical Association at French Lick, the Instructional Course program will be presented on Monday, the opening day of the session. Beginning at 11:00 a.m. and continuing at 1:00, 2:00, 3:00 and 4:00 p.m., classes will be conducted in the problems currently of interest to members of our Association. Each class will again be limited to a maximum of 30 auditors. The general plan for these classes is that presentation will be made by someone particularly interested in the subject, following which a brief opportunity for questions and discussion will be provided. The facilities at the French Lick Hotel are such as to assure us of adequate classroom privacy for this course. The schedule of the 30 classes to be offered will be found elsewhere in this issue. It is always advisable to make reservations now for the classes you will wish to attend, as the majority of the courses have been filled by Registration Day at the convention.

PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

Name and Residence	Elected	Served
Medical Convention		
*Livingston Dunlap, Indianapolis	1849	1849
Medical Society		
*William T. S. Cornett, Versailles	1849	1850
*Ashahel Clapp, New Albany	1850	1851
*George W. Mears, Indianapolis	1851	1852
*Jeremiah H. Brower, Lawrenceburg	1852	1853
*Elizur H. Deming, Lafayette	1853	1854
*Madison J. Bray, Evansville	1854	1855
*William Lomax, Marion	1855	1856
*Daniel Meeker, LaPorte	1856	1857
*Talbot Bullard, Indianapolis	1857	1858
*Nathan Johnson, Cambridge City	1858	1859
*David Hutchinson, Mooresville	1859	1860
*Benjamin S. Woodworth, Ft. Wayne	1860	1861
*Theophilus Parvin, Indianapolis	1861	1862
*James F. Hibberd, Richmond	1862	1863
*John Sloan, New Albany	1863	----
*John Moffett (acting), Rushville	1863	1864
*Samuel L. Linton, Columbus	1864	----
*Wilson Lockhart (acting), Danville	1864	1865
*Myron H. Harding, Lawrenceburg	1865	1866
*Vierling Kersey, Richmond	1866	1867
*John S. Bobbs, Indianapolis	1867	1868
*Nathaniel Field, Jeffersonville	1868	1869
*George Sutton, Aurora	1869	1870
*Robert N. Todd, Indianapolis	1870	1871
*Henry P. Ayres, Ft. Wayne	1871	1872
*Joel Pennington, Milton	1872	1873
*Isaac Casselberry, Evansville	1873	----
*Wilson Hobbs (acting), Knightstown	1873	1874
*Richard E. Houghton, Richmond	1874	1875
*John H. Helm, Peru	1875	1876
*Samuel S. Boyd, Dublin	1876	1877
*Luther D. Waterman, Indianapolis	1877	1878
*Louis Humphreys, South Bend	1878	----
*Benj. Newland (acting), Bedford (v.p.)	1878	1879
*Jacob R. Weist, Richmond	1879	1880
*Thomas B. Harvey, Indianapolis	1880	1881
*Marshall Sexton, Rushville	1881	1882
*William H. Bell, Logansport	1882	1883
*Samuel E. Mumford, Princeton	1883	1884
*James H. Woodburn, Indianapolis	1884	1885
*James S. Gregg, Ft. Wayne	1885	1886
*General W. H. Kemper, Muncie	1886	1887
*Samuel H. Charlton, Seymour	1887	1888
*William H. Wishard, Indianapolis	1888	1889
*James D. Gatch, Lawrenceburg	1889	1890
*Gonsolvo C. Smythe, Greencastle	1890	1891
*Edwin Walker, Evansville	1891	1892
*George F. Beasley, Lafayette	1892	1893
*Charles A. Daugherty, South Bend	1893	1894
*Elijah S. Elder, Indianapolis	1894	----
Charles S. Bond (acting), Richmond	1894	1895
*Miles F. Porter, Ft. Wayne	1895	1896
*James H. Ford, Wabash	1896	1897
*William N. Wishard, Indianapolis	1897	1898
*John C. Sexton, Rushville	1898	1899
*Walker Schell, Terre Haute	1899	1900
*George W. McCaskey, Ft. Wayne	1900	1901
*Alembert W. Brayton, Indianapolis	1901	1902
*John B. Berteling, South Bend	1902	1903
Medical Association		
*Jonas Stewart, Anderson	1903	1904
*George T. MacCoy, Columbus	1904	1905
*George H. Grant, Richmond	1905	1906
*George J. Cook, Indianapolis	1906	1907
*David C. Peyton, Jeffersonville	1907	1908
*George D. Kahlo, French Lick	1908	1909
*Thomas C. Kennedy, Shelbyville	1909	1910
*Frederick C. Heath, Indianapolis	1910	1911
*William F. Howat, Hammond	1911	1912
*A. C. Kimberlin, Indianapolis	1912	1913
*John P. Salb, Jasper	1913	1914
*Frank B. Wynn, Indianapolis	1914	1915
*George F. Keiper, Lafayette	1915	1916
*John H. Oliver, Indianapolis	1916	1917
*Joseph Rilus Eastman, Indianapolis	1917	1918
William H. Stemm, North Vernon	1918	1919
*Charles H. McCully, Logansport	1919	1920
*David Ross, Indianapolis	1920	1921
William R. Davidson, Evansville	1921	1922
*Charles H. Good, Huntington	1922	1923
*Samuel E. Earp, Indianapolis	1923	1924
Eldridge M. Shanklin, Hammond	1924	1925
Charles N. Combs, Terre Haute	1925	1926
*Frank W. Cregor, Indianapolis	1926	1927
George R. Daniels, Marion	1926	1928
Charles E. Gillespie, Seymour	1927	1929
*Angus C. McDonald, Warsaw	1928	1930
*Alois B. Graham, Indianapolis	1929	1931
Franklin S. Crockett, Lafayette	1930	1932
Joseph H. Weinstein, Terre Haute	1931	1933
Everett E. Padgett, Indianapolis	1932	1934
*Walter J. Leach, New Albany	1933	1935
Roscoe L. Sensenich, South Bend	1934	1936
*Edmund D. Clark, Indianapolis	1935	1937
Herman M. Baker, Evansville	1936	1938
*Edmund M. Van Buskirk, Ft. Wayne	1937	1939
Karl R. Ruddell, Indianapolis	1938	1940
Albert M. Mitchell, Terre Haute	1939	1941
Maynard A. Austin, Anderson	1940	1942
Carl H. McCaskey, Indianapolis	1941	1943
Jacob T. Oliphant, Farmersburg	1942	1944
Neslen K. Forster, Hammond	1943	1945
Jesse E. Ferrell, Fortville	1944	1946
Floyd T. Romberger, Lafayette	1945	1947
Cleon A. Nafe, Indianapolis	1946	1948
Augustus P. Hauss, New Albany	1947	1949
C. S. Black, Warren	1948	1950

* Deceased.

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Office of Publication: 1017 Hume Mansur Building

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Editor Emeritus: E. M. Shanklin, M.D., Hammond, Indiana

Editor: Frank B. Ramsey, M.D., 201 Hume Mansur Building, Indianapolis 4, Indiana.
Associate Editor: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana.
Managing Editor: Ray E. Smith, 1017 Hume Mansur Building, Indianapolis 4, Indiana.
Editorial Secretary: Mrs. Isabella Rowlison, 1017 Hume Mansur Building, Indianapolis 4, Indiana.

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THE YEAR BOOK—1950 EDITION

THE fourth edition of the Indiana Medical Year Book is presented herewith. It has been compiled as a reference book for year-round use, and has been assembled on the same general principles as its predecessors. It is complete with a calendar to symbolize its usefulness throughout the coming twelve months. It is hoped that the durable cover will preserve its contents for frequent use and enable its retention as a reference for several years to come.

The membership rosters have been carefully revised and arranged. Reference material in regard to medical institutions and medical organizations of the state has been brought up-to-date. Several authoritative articles on medicolegal subjects not covered heretofore are included.

Mr. Albert Stump, attorney for the state association, has reviewed the medicolegal contents of the three former Year Books to determine whether the 1947, 1948 and 1949 issues may be considered authentic. He finds that none of the previous articles is in need of revision. An index of all of the previous and present articles dealing with medical jurisprudence and allied subjects which have been published in the four Year Books appears in this issue for the convenience of those who wish to refer to former numbers.

In addition to the above-mentioned articles, documents are presented by the administrative heads of two state agencies which have frequent contacts with the medical profession, the State Industrial Board and the State Department of Public Welfare.

Mr. Harrell's explanation of the rules of procedure before the Industrial Board is of interest to all physicians, but will be especially helpful to those who are concerned rather infrequently with industrial compensation cases. The rules for determining disability under the Workmen's Compensation Act will make a worth-while reference.

The medical activities of the State Welfare Department, and the widely varying administrative policies of the various counties is set out in an informative report by the State Welfare Administrator, Mr. Maurice O. Hunt.

THE JOURNAL is deeply indebted to the authors of the special articles of the Year Book, and wishes to express appreciation for the research work and careful preparation which has been expended in the assembling of this reference issue. Special thanks are due the members of the association headquarters office and THE JOURNAL staff for many hours of detailed work which has been necessary for this publication.

CIVILIAN DEFENSE PROGRAM

"THE Civil Defense Act of 1949" created a Department of Civil Defense for the state of Indiana. This agency is directly under the control of the Governor, with the Superintendent of State Police as its director.

The Act also created a Civil Defense Advisory Council with members of the State Police Board as ex-officio members, and with provision of appointment by the Governor of additional members. At present the Council includes the Adjutant General, the State Fire Marshal, the heads of the State Conservation Department, Board of Health, Department of Labor, and Department of Public Welfare, the director of maintenance of the State Highway Department, the state relations director of the Red Cross, and the chairman of the Emergency Medical Manpower Committee of the Indiana State Medical Association.

Headquarters for the Department have been organized at Stout Field, Indianapolis, with the State Police Headquarters. Lt. Frederick Cretors of the Indiana State Police has been appointed as deputy director by State Police Superintendent Arthur M. Thurston.

Plans for civil defense in an atomic age must be considerably more extensive and detailed than those which were considered adequate in years gone by. They must include not only active measures to protect us against attack, but must also provide uncomplicated directions for the control of possible widespread property damage, and for the care of numerous casualties.

Planning has been started with a study of existing resources of major importance. Chief among these are:

1. Water supply systems, especially reserve supplies. An atomic explosion over a city, even though it does not damage the reservoir system itself, will destroy so many outlets that pressure cannot be maintained in the distribution mains. An emergency supply of potable water would be of the utmost importance, and means for its distribution would be equally essential.

2. Means of communication. A devastated area will be dependent initially on primitive means of communication. An ideal civil defense plan should be so comprehensive, and the public should be familiar enough with it, so that most of the population could proceed with the proper control and relief tasks without instructions or direction.

3. Street and highway systems. These will be clogged with debris, and must be cleared early to allow evacuation of casualties and the ingress of relief organizations. Study should indicate which routes are likely to be most susceptible for clearing, so that delay will not be occasioned by early work on the most difficult part of the task.

4. Means of transportation. Railroads, busses, and all other types of wheeled transportation will be needed. Effective traffic control will allow the most efficient use for evacuation purposes.

5. Emergency shelter. An atomic explosion, particularly during inclement weather, would create a tremendous housing problem. The provision of hospital and first-aid facilities would be equally trying.

These are but a few of the gigantic problems which are facing our Civil Defense Council. Fortunately these problems are gigantic only if they are thrust upon us in an unprepared state. Orderly and systematic planning will reduce them in size. Public education, judiciously carried out, will bring their solution closer and closer.

It has often been said that the American people are unique in their propensity to prepare for war and similar catastrophes after the crisis has arisen. This is one time, however, when this old American custom will have to be discarded. Preparation for defense against atomic warfare, however slight the possibility may be, must and should be made now.

ALL IS NOT GOLD THAT GLITTERS

THE central part of our country is inhabited by a number of hard-headed citizens who not only know that "not all is gold that glitters" but who resist being led by those who look only for the glitter.

The president of the Iowa State Medical Society, who is also president of the Mississippi Valley Medical Society, is concerned about the possibly deceptive glitter of federal grants for medical education. He writes in the *Mississippi Valley Medical Journal*, (in part) as follows:

> The whole setting is perfect to create an effective appeal for votes, and, therefore, for the success of these steps toward socialism. On the surface it is a noble and appealing thought and, therefore, extremely deceptive and extremely insidious.
>
> Whenever a grant is made to an educational institution whether it be from an individual, from a foundation, or from a government, strings and controls, written and unwritten, go with that gift. If the gift comes from an individual, the individual's life is short and the duration of the influence is limited. If it comes from a foundation it usually comes with thought and wisdom behind it, and these strings may not be particularly harmful. However, when it comes from our federal government, which is far, far away from the taxpayer, and when it comes with political implications as to its primary stimulant, then the danger is most insidious and most deceptive. Remember this, that what the federal government subsidizes, that it can control. If the socializers of federal government can control medical education, our medical schools will attract to them and be staffed by men of the socialistic type of mind, and in our institutions the young men who are to be our successors will be subjected in their formative and impressive years to this atmosphere, and will be well indoctrinated with the principles of the socialistic state when they go out to practice their art.

The California Medical Association recognized

the need to combat false prophets and foolish doctrines in the education of physicians some time ago when it inaugurated by resolution a committee to formulate means of proper indoctrination of interns, especially, in the field of medical economics. This is one area of "preventive medicine" which has been left largely to chance. Shall we in Indiana be less alert than our colleagues in California and Iowa?

THE GENERAL PRACTITIONER IN THE HOSPITAL*

MANY members of the profession, in both general and consultant practice, are disturbed at the increasing segregation of general practitioners from hospital work. Though the developments in medicine over the last decade or so are partly responsible, they ought to have had exactly the opposite effect if the greatest benefit is to be obtained from them. New diagnostic tests and decisively beneficial drugs have drawn many more sick people than formerly within the ambit of hospital practice, but in doing so they have tended to withdraw patients from time to time from the care of general practitioners into that of consultants and other hospital workers. A distinction always present has therefore been accentuated rather than reduced. Hospital staffs have had to waste time doing work well within the capacity of general practitioners, and the family doctor may come to be revered more for his certificates than for his prescriptions. Many general practitioners writing to this *Journal* have complained of their isolation from hospitals, where the latest ideas are necessarily put into practice, and also of what is in effect an increasing isolation from their patients. The result is detrimental not merely to general practice but to medicine as a whole. A committee of the B.M.A. representative of both general practitioners and consultants is at present studying the problem, and its report will be awaited with interest.

. . . . . .

Last October the Minister of Health made an attempt that was generally welcomed to induce hospital boards to take a wider view of their responsibilities. In Circular R.H.B. (49) 132 he emphasized the value of general-practitioner beds in hospitals, both to patients and general practitioners. He might have gone further and added that consultants are wasting their special ability and experience if they have charge of patients who could as well be in the care of general practitioners. Yet attempts are still being made to deprive general practitioners of hospital beds, and even though some decisions have been reversed general practitioners on the whole probably have fewer beds in their care than when the Health Service started. It might be helpful if all regional boards were required to include some general practitioners in their membership, and the Ministry is to be asked about the possibility of this. At present the medical representation is overwhelmingly consultant, and the board's decisions tend to reflect rather than to transcend professional distinctions. If general practitioners are to become, as they should, partners of the consultants rather than related by the tenuous formality of a "doctor's letter," a closer association in the administrative framework is desirable.

* Excerpts from an editorial in *The British Medical Journal* of March 18, 1950.

Editorial Notes

ESSAYS ON MEDICAL CARE

The Owen-Monroe County Medical Society sponsored a public meeting at Bloomington High School auditorium on May 10. Thirteen cash prizes were awarded for essays written on the subject "Why the Private Practice of Medicine Furnishes this Country with the Finest Medical Care." The essay contest was sponsored by the medical society and the American Association of Physicians and Surgeons. Lawrence Wheeler of Indiana University spoke at the meeting on "Freedom versus Socialism." Mr. Cecil Moore, president of the Monroe County Farm Bureau, gave a talk on "Farmers, Socialism and the Brannan Plan." The first and second prize essays were read by their authors. The essays winning the first three places and honorable mention will be entered in the national contest.

"THE HUMAN HEART"

The Public Health Service has reproduced a series of articles on "The Human Heart" in a 22-page pamphlet for distribution to the public. It is a reprint of material which was published originally in *The Washington Post*, Washington, D. C., and is issued by the National Heart Institute to meet a large number of requests from the public for information. A single copy may be secured without cost by writing to the Heart Information Center, National Heart Institute, Bethesda 14, Maryland. Additional copies may be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 15c per copy, with a 25 percent discount on orders of 100 or more mailed in bulk to one address.

President's Page

THE INDIANA UNIVERSITY MEDICAL CENTER

ONE cannot help but marvel at the tremendous building program which is now under way at our fine medical center. With the expansion of present facilities it is possible to accept 150 medical students for each year's class in the Indiana University School of Medicine. Indiana is keeping step with the march of medical progress over the entire world. The centralization of the various branches of medicine makes the Indianapolis campus one of the great medical training centers in America.

Even better coordination and more efficient operation of courses will result as soon as all four years of medicine are taught on the Indianapolis campus, and I hope this will come to pass in the very near future, for it will enable medical students to realize a more complete association with the profession and the medical school itself.

It is encouraging to note that a recent survey of medical students indicated a greater number interested in general practice. This is good, because we need more general practitioners in order to provide a competent medical service which is available to all of the people all of the time. From our own progressive medical center will come these men, trained in an institution second to none.

E. S. Black,

Medical Panorama by the Associate Editor

The Deadly Blight

Once embarked on the rigid, undeviating course of collectivistic totalitarianism, there is no turning back and no compromise. The steam-roller ruthlessness of the system is appalling, and is applied willy-nilly to all phases of living—even to Science. The Lysenko purge among biologists is a flagrant example. Now comes *The New York State Journal of Medicine*, May 1, 1950, calling attention to another bureaucratic ax which strikes at the roots of scientific medicine. Read this excerpt and see how men can be blinded by an obsession—even a political one.

We note with curiosity a dispatch from Moscow, U. S. S. R., concerning a purge in Soviet medicine presently being conducted. The purpose is reported to be the elimination of "the influence of antirevolutionary, antimaterialistic, and idealistic positions in the pathology of Virchow, Ehrlich, Pasteur, Koch, and others." Academician A. D. Speransky is reported to be leading this movement by the Soviet Academy of Medical Sciences with the purpose of purging Soviet medicine of tendencies said to be the counterparts of the influences already eliminated from Soviet biology under the leadership of T. D. Lysenko.

The attack is reported to be directed particularly against the "cellular theories" of Virchow, and "the associated principles of Pasteur, Koch, and Ehrlich." Since the ideas and work of these hitherto respectable, certainly scientific, and frequently brilliant gentlemen is to be scrapped in the U. S. S. R. for no better reason apparently than that they are "antirevolutionary, antimaterialistic, and idealistic," we are afforded a very real glimpse of what goes on in medicine behind the Iron Curtain.

What concepts will supplant these erroneous "bourgeois" notions? Possibly a "single unitary theory of medicine rooted in such concepts as Pavlov's 'nervism'"; the biology of Timirayzev, Michurin, and Lysenko; the physiology of Sechenov and Pavlov, and the clinical work of Botkin. Thus, Soviet medicine—revolutionary, materialistic, and nonidealistic—will increasingly cleave to the revolutionary party line.

* * *

We touch lightly on this item from behind the Iron Curtain in the belief that our physician readers, most of whom probably feel indebted to the classic work of Virchow, Pasteur, Koch, Ehrlich, and their followers, may appreciate more keenly the advantages of medical education and practice in a free community.

Let us hope that certain obsessions among "planners" in this hemisphere are not allowed to become entrenched so as to lead to anything remotely similar to that indicated above.

Toxicology Again

Behold, new and fearful poisons appear overnight, almost, in this age of jet-propelled chemistry—"fearful" in this particular instance because of their workaday use by people accustomed to dealing with less toxic products, who do not appreciate the danger. *The West Virginia Medical Journal* for May, 1950, editorializes, in part, as follows:

The active insecticides parathion and its related compounds HETP and TEPP have been used in West Virginia fruit growing areas with great success in the control of destructive pests. Unfortunately these compounds are exceedingly toxic for man, and poisoning is certain to occur unless great care is used.

During the 1949 season at least three deaths from parathion poisoning occurred in the United States. In these cases the outcome resulted from lack of adequate protective measures and from failure to seek medical aid at the onset of symptoms.

* * *

It becomes the duty of physicians in fruit growing areas to familiarize themselves with this new type of poisoning, and to be prepared to treat it intelligently.

Early, active treatment usually is successful, and is described in the same journal by J. J. Lawless, M.D.

Early symptoms of poisoning include headache, blurred vision, nausea, dizziness, dyspnea, cramps and diarrhea. At the onset of any of these symptoms, the use of parathion should be stopped immediately, and a physician consulted. The immediate administration of atropine is desirable . . . and should be used in doses sufficient to keep the patient fully atropinized. Doses of 1 to 2 mg. (gr. 1/60 to 1/30) may be given hourly up to 10 or 20 mg. daily. It may be necessary to invert the patient to aid in the coughing out of mucus, or it may be necessary to remove mucus by means of a tracheal catheter. The stomach should be emptied of accumulated secretion by means of a Levin tube, and oxygen should be administered early because of the danger of pulmonary edema. Muscular weakness may be so extreme as to require artificial respiration. The emergency lasts from twenty-four to forty-eight hours, and the patient must be watched carefully during this period. Recovery may be hoped for even in severe poisoning, requiring many hours of artificial respiration.

It is further stated that susceptibility to this poison "is increased after one episode."

Since Indiana raises fruit, too, we pass this on for the Hoosier doctor to note for possible future reference.

EXPERIMENT IN SOCIALIZED MEDICINE TRIED BY INDIANA COMPANY; FAILED

A. J. Heuring*

Winslow

WE READ these days a great deal about socialized medicine, health security, both pro and con. As I read the various arguments I am carried back to the days when we had a socialized health plan right here in Pike county. When the late David Ingle opened his first deep mine, soon afterward, in 1881 it first started. The miners decided they would band together and hire a doctor to take care of their medical needs. The late Dr. David DeTar was the first man they hired. They agreed to a check off each two weeks of 50c for the single men and 75c for each married man. All this provided the man had anything coming to him that had not been taken up at the company store. The physician would turn in the names of the men who went on his list and he would get his check each month from the Ingle company. This continued from 1881 until some time in the nineteen hundred and twenties. Among the other physicians who had the work during the time were Doctor McGrew, Doctor Whaley, Dr. T. D. McGlasson, a Doctor Garrison and the firm of Drs. David and George B. DeTar.

The plan saved money for some but others it cost. Many families felt that because they were on the list that they should have some service whether they needed it or not, and they called the doctor. They appeared to feel that since they were paying for a doctor's services they should use him. His calls were many and varied. In the rounds some of the fellows never had anything left for the company to check off. One physician told me of a large family he carried through weeks and weeks of typhoid fever for which he never received a cent, but the family was on his list. Now and then a new baby would come into some of the families and the doctor would get a little extra for that, as the contract specified. Now and then a married daughter would come home for a month or six weeks and in the rounds the doctor would be called to deliver the baby, for she was at home and that would mean several dollars saving. He would be a busy man and seldom able to take care of any private practice, in the rounds of treating simple things which, had the patient been paying the regular fee for the doctor's service, the doctor never would have been called.

The doctor grew more or less careless and lost interest in his profession. As a rule the physician had to have a driver and one ready to go at all hours of the day or night. The large number of the miners observed the contract and called the physician only in cases of actual need, but there were those who paid little or nothing, never having anything coming to check off, and they called for his services more than those who called only when his services were needed. Many families who paid each payday would use the doctor only when needed and often he would not be in their homes in a year. Others would go to his office and call for medicine, much of which was never used. It was these men who finally killed the "socialized medicine" among the miners.

There has been going on in Pike county for the past several years among the medical profession an immunizing of children against the diseases we long endured, which has driven many of the diseases out of the country. It is easy for me to remember the great scourge of diphtheria in my neighborhood, the net in which I was caught, and followed a little white casket to Oak Hills cemetery, in which lay the remains of an 8-year-old son, while his brother, 27 months younger, was sent away from home where he remained until the plague was over.

Who has heard of a case of diphtheria in Pike county in the last twenty years? Or a case of scarlet fever? I do not remember a case of typhoid fever in the last fifteen years. Would we have had this immunization if we had had a socialized medicine when a physician would be hired out just as an unskilled hand would be? And all this almost without money or price, fully so as far as the physician is concerned as he got not a cent for his own pocket. And to those who could not pay a half dollar the service was wholly free. Only those who paid the bill with their own blood know the value of the work the physicians have done in the last more than thirty years to expel these diseases from the land. A great howl has been raised because the physicians throughout the land are fighting it because of the damage to their profession. And I would be just like them if the fight was against my business for it will deteriorate the profession and shut out advancement and slow down the fight against diseases.

Too many of our people are looking for a material security in pensions, doles and free service at the expense of others. That is not the security that made this nation great. That is not the plan

* Mr. Heuring is editor of *The Pike County Dispatch*. A Democrat, and past president of the Indiana Democratic Editorial Association, he is nevertheless opposed to compulsory sickness insurance.

by which our forefathers crossed the Mississippi river, lived in sod shacks to find a security where they could carve out a place in the world for themselves and their posterity. If they had possessed the present security idea of purely sufficient income without work, the great United States west would still be roamed by buffalo. England is trying it out. They are behind in their payments to doctors, hospitals and drug stores and the tax proposition is enormous. Doctors are run ragged as the people are treating it much like many of the coal miners did when they had company doctors. Since they are paying for service in taxes they feel they should have some service whether they need it or not.

If the physicians have money to fight this thing which will stop the progress of their profession, and they will use it to inform the public, the public will not stand for it. Here in Pike county the local medical society has done much in driving out communicable diseases, have given of their time, talent and money toward the work, all of which would come to a quick halt under socialized medicine, for they would have more who demanded something for nothing than the coal miners ever did.

DEATHS OF INDIANA PHYSICIANS IN 1948 AND 1949

(Compiled by James B. Maple, M.D., chairman of Committee on Necrology)

(M) Member I.S.M.A.; (H) Honorary Member; (R) Retired

Name	Age	Date of Death 1948		Address	Cause of Death
Brink, John Calvin (M)	35	Jan.	5	Gary	Uremia. Chronic glomerulonephritis. Hypertension.
Teague, Mabel Madsen (R)	78	Jan.	9	Indianapolis	Coronary thrombosis.
Boone, John C. (H)	82	Jan.	11	South Bend	Coronary thrombosis.
Conkling, Clifford W.	78	Jan.	13	Windfall	Cerebral hemorrhage.
Hadley, Alfred Wilburn (M)	74	Jan.	16	Indianapolis	Cerebral hemorrhage.
Ramsey, John P. (H)	85	Jan.	22	Vincennes	Chronic myocarditis. Upper respiratory tract infection.
Dean, Michael Francis	66	Jan.		Indianapolis	Coronary occlusion. Diabetes mellitus.
English, Calvin H. (H)	90	Feb.	4	Fort Wayne	Pneumonia.
Graham, Henry James (R)	72	Feb.	6	Mishawaka	Coronary thrombosis.
Fagley, Arthur Thomas (H)	77	Feb.	11	Lawrenceburg	Myocardial degeneration.
Inlow, Charles F. (M)	53	Feb.	14	Shelbyville	Hypertension.
McKay, James Donald (H)	78	Feb.	18	Marion	Coronary occlusion.
Bounell, Emery G. (H)	76	Feb.	20	Hillsboro	Fall.
Hines, Dorsey Mark (M)	61	Feb.	25	Auburn	Nephritis.
Chapin, Charles Cox (M)	55	Feb.	26	Lafayette	Organic heart disease.
Loomis, John F. (R) (H)	83	Mar.	3	Marion	Pulmonary embolism. Fracture of hip.
Davis, Henry Glover	65	Mar.	4	Franklin	Cerebral hemorrhage.
Hamilton, Eugene E. (M)	69	Mar.	9	Dayton	Gunshot wound of head. Suicide.
Walkinshaw, William (H)	81	Mar.	10	Stillwell	Heart disease.
Thomas, Clarkson B. (R.M.)	71	Mar.	13	Plainfield	Coronary occlusion.
Whitehill, John E.	63	Mar.	16	South Bend	Cerebral hemorrhage. Hypostatic pneumonia.
Wray, Curtis M. (M)	71	Mar.	17	Lafayette	Coronary occlusion.
Ostrowski, Leonard J. (M)	81	Mar.	28	East Chicago	Asphyxiation from gas.
Allenbaugh, Arleigh E. (M)	52	Apr.	3	Evansville	Chronic coronary. Pulmonary emphysema. Bronchiectasis.
Chandler, Joseph S.	24	Apr.	3	Muncie	Shock. Sensitivity to pontocaine during tonsillectomy.
Graham, Cova Roy (M)	62	Apr.	3	Bourbon	Coronary occlusion.
Clark, Carl McLaughlin (M)	48	Apr.	4	Oakland City	Hodgkins disease.
Graham, Alvis B. (H. R.)	77	Apr.	5	Indianapolis	
Davidson, Carl V. (M)	67	Apr.	7	Williamsport	Carcinoma of the pancreas.
Reynolds, Francis M. (M)	78	Apr.	16	Montpelier	Coronary disease.
Swarts, Willard W. (R.H.)	76	Apr.	24	Auburn	
Lohman, Maurice R. (M)	58	Apr.	29	Fort Wayne	Bilateral pyelonephritis. Hypertrophic prostatitis.
McNaull, Charles M. (H.R.)	84	May	16	Indianapolis	Coronary occlusion.
Phillips, William O.	69	May	20	Newburgh	Carcinoma of the common duct.
Slabaugh, Lotus M. (M)	46	May	21	Nappanee	Coronary occlusion.

Name	Age	Date of Death 1948		Address	Cause of Death
Goss, Herschel W. (M)	44	May	21	Indianapolis	Cerebral hemorrhage. Malignant hypertension.
Barnes, William E. (R)	56	May	23	Evansville	Cerebral hemorrhage.
Deen, Henry H. (M)	72	May	29	Leavenworth	Gunshot wound—self-inflicted.
Christie, J. Preston	65	June	2	North Madison	Arteriosclerotic heart disease.
Otto, Anthony E. (H)	86	June	3	Alexandria	C. V. R. D.
Woods, William V. (M)	45	June	3	Indianapolis	Coronary thrombosis.
McBride, Earle C. (M)	73	June	5	Terre Haute	Coronary occlusion.
Allenbaugh, Elmer E. (R)	87	June	6	Dale	Myocarditis.
Wright, Walter W. (M)	65	June	17	New Castle	Rupture of aortic aneurysm. Aortic arteriosclerosis.
Kraft, Ralph W. (M)	38	June	23	Hobart	Gunshot, accidental.
Benham, James Wesley (H)	79	June	26	Columbus	Coronary occlusion.
Morrison, James H. (R)	81	June	29	Hartsville	Cerebral hemorrhage.
Mace, Elmer E. (M)	71	July	1	New Palestine	Coronary occlusion.
Brown, Harry M. (M)	33	July	2	Indianapolis	Auto accident.
Stauffer, Horace R. (R)	90	July	2	Nappanee	
Riley, Elden T. (H)	80	July	3	Greensburg	Pneumonia. Diabetes mellitus.
Boyd-Snee, Harry (R.H.)	78	July	4	South Bend	Acute terminal bronchopneumonia.
Stalker, James B. (M)	72	July	6	Indianapolis	Coronary occlusion.
Jenkins, James M. (H)	83	July	9	Courtland	Coronary thrombosis.
Shannon, Rollin R.	44	July	14	Williamsport	Auto accident.
Davenner, F. W. (M)	57	July	22	Gas City	Adenocarcinoma of bladder.
Wagner, Samuel C. (M)	73	July	27	Elkhart	Congestive heart failure.
Giorgi, Antonio (H.R.)	85	July	30	Gary	Coronary occlusion.
Hunt, William B. (H)	87	July	31	Terre Haute	Heart disease.
Wheat, Wallace W.	70	Aug.		Rosedale	Carcinoma of the liver.
Royster, Hollace R. (M)	59	Aug.	6	Frankfort	Coronary occlusion.
Estel, Gottfried A. (M)	68	Aug.	20	North Madison	Chronic endocarditis.
Rendel, Charles F. (M)	73	Sept.	1	Mexico	Coronary occlusion.
Braginton, Fred (H)	86	Sept.	2	Hammond	Cardiac decompensation.
Goodale, Albert W.	75	Sept.	10	Orland	
King, Richard F.	93	Sept.	12	Jamestown	C. V. R. D.
Stephenson, Chester E.	71	Sept.	22	Indianapolis	Arteriosclerotic heart disease; general arteriosclerosis.
Wishard, Frederick B. (M)	54	Sept.	23	Anderson	Coronary thrombosis.
Zimmerman, Russell G. (M)	45	Sept.	24	Berne	Cerebral hemorrhage.
Karras, George L.	50	Sept.	30	Gary	Acute myocarditis; chronic nephritis.
Alburger, Henry R. (M)	74	Oct.	7	Indianapolis	Cerebral hemorrhage.
Reed, Lewis D. (H)	85	Oct.	16	Hope	Carcinoma of the intestines.
Smith, H. Brooks (M)	40	Oct.	18	Bluffton	Malignant hypertension.
Arnold, Ralph N. (M)	55	Oct.	19	Greenfield	Coronary occlusion.
Landis, William C.	67	Oct.	19	Claypool	Vesico intestinal fistula.
Thomas, Wesley M.	80	Oct.	21	Westville	Cerebral hemorrhage.
Hoppes, Gilbert A.	58	Oct.	22	Anderson	C. V. R. D.
Taylor, Daniel E. (H)	79	Oct.	25	Velpen	Carcinoma of the stomach.
Pettigrew, Charles D.	72	Oct.	27	Muncie	Coronary thrombosis.
Aldrich, Harry (M)	63	Oct.	31	Fort Wayne	Periarteritis nodosa.
Derian, Mardiros H. (M)	61	Nov.	1	Gary	Pulmonary embolism; purulent pericarditis.
Beresford, George B. (H)	85	Nov.	5	Owensville	Uremia.
Westhafer, Edison K. (M)	70	Nov.	9	Newcastle	Coronary occlusion.
Lloyd, Aljah W.	78	Nov.	19	Hammond	Coronary thrombosis.
Erwin, Harry G. (M)	65	Nov.	25	LaGrange	Carcinoma of the gall bladder and liver.
Cotton, Perry E. (M)	40	Nov.	29	Elwood	Auto-train wreck.
Fisher, Albert (M)	70	Dec.	3	North Judson	Cardiac decompensation; lymphosarcoma.
Beatty, Norman M. (M)	46	Dec.	5	Indianapolis	Coronary thrombosis; hypertensive cardiovascular disease.
Bunch, Rollin H. (M)	66	Dec.	9	Muncie	Coronary thrombosis; myocardial infarction.
Basler, Samuel D.	99	Dec.	12	Columbia City	Fall.
Tate, Wallace W. (M)	73	Dec.	13	Thayer	Coronary disease.
Welborn, James Y. (M)	75	Dec.	21	Evansville	Carcinoma of the pancreas.
Tremor, Victor F. (M)	53	Dec.	31	Indianapolis	Myocardial infarction.

Name	Age	Date of Death 1949		Address	Cause of Death
Greene, Lowell McKee (M)	66	Jan.	3	Rushville	Coronary occlusion.
Boone, John Calhoun	82	Jan.	11	South Bend	Coronary thrombosis.
Eichelberger, William W. (M)	70	Jan.	12	Evansville	Coronary heart disease.
Baldridge, Ezra R. (M)	75	Jan.	15	Terre Haute	Coronary thrombosis; myocardial infarction.
Shuler, Lacey L. (M)	56	Jan.	15	Indianapolis	Rheumatic heart disease.
Eberhart, Lester L. (M)	51	Jan.	18	Angola	Coronary occlusion.
Kennedy, Samuel (H)	81	Feb.	1	Shelbyville	Cerebral hemorrhage.
Markley, Henry W. (M)	76	Feb.	5	Rochester	Coronary occlusion.
Mott, Luther A.	77	Feb.	7	Elwood	Cerebral hemorrhage.
Blinks, Edward G. (H.R.)	80	Feb.	11	Michigan City	Coronary thrombosis; C. V. R. D.
Workman, William S. (R)	91	Feb.	13	Indianapolis	Pulmonary tuberculosis.
Kinsey, Joseph H. (M)	82	Feb.	14	Richmond	Congestive heart failure.
Watts, Albert A. (M.R.)	61	Feb.	19	Gary	Chronic myocarditis; virus pneumonia.
Butler, Raymond A. (M)	64	Feb.	25	Beech Grove	Nephrosclerosis.
Funkhouser, Ralph Moody	64	Feb.	27	Indianapolis	Cancer of the pancreas.
Tade, Ellis H.	70	Feb.	29	Bicknell	Heart disease.
Bowell, Bowen C.	79	Mar.	2	LaPorte	Cerebral hemorrhage.
Lewis, James L. (M)	76	Mar.	29	Danville	
McCulloch, Carleton B. (H)	77	Apr.	5	Indianapolis	Coronary heart disease.
Thurston, Alpheus L. (M)	65	Apr.	21	Indianapolis	Cerebral hemorrhage.
Lauer, Aron J. (R.H.)	78	Apr.	30	Whiting	Coronary occlusion.
Kincaid, John C. (M)	69	May	8	Columbus	Acute cardiac decompensation; coronary sclerosis; myocardial fibrosis.
Boone, Bryan H. (R)	83	May	19	Acton	Carcinoma of the prostate.
Kamman, Herman H. (H)	77	May	20	Columbus	Cerebral hemorrhage; arteriosclerosis.
Rhamy, Bonnelle W. (M)	75	May	26	Fort Wayne	Arteriosclerotic heart disease; diabetes mellitus.
Havens, Edward D. (M)	73	May	30	Cicero	Cerebral contusion from fall.
Ostrowski, Romuald O. (M)	68	June	3	Hammond	Coronary thrombosis.
Baker, Walter H. (M)	72	June	6	South Bend	Cerebral aneurysm.
Study, Joseph N. (R.H.)	98	June	13	Cambridge City	Uremia; arteriosclerosis.
Foltz, Charles J. (M)	53	June	16	Evansville	Coronary thrombosis.
Knue, George F.	64	June	25	Indianapolis	General arteriosclerosis.
Snedeker, Alfred W.	51	June	29	Richmond	Coronary occlusion.
Egan, Burton W. (R.M.)	72	June	30	Logansport	Coronary occlusion.
Marshall, Augustus L. (R.M.)	73	July	1	Indianapolis	Cerebral hemorrhage.
Silvers, Joseph C. (M)	47	July	3	Muncie	Cerebral hemorrhage; hypertension.
Hargis, William T. (H)	84	July	8	Tell City	Carcinoma of colon and liver.
Wallace, J. Clifford (M)	73	July	13	Fort Wayne	C. V. R. D. with hypertension.
Phillips, Harold E.	55	July	14	Indianapolis	Carcinoma of the esophagus.
Strange, Martin B. (M)	42	July	15	New Albany	Coronary thrombosis.
Charles, Etta (H)	87	July	16	Anderson	Chronic congestive heart failure.
Christophel, Walter B. (R.M.)	69	July	21	Mishawaka	Cerebral hemorrhage.
Grossnickle, George W. (M)	69	July	27	Elkhart	Acute coronary occlusion.
Hauss, Quincy R. (R)	84	Aug.	10	Sellersburg	Died following prostatic operation.
Miller, Elizabeth (R)	88	Aug.	10	Indianapolis	
Leach, Leon T.	73	Aug.	15	Indianapolis	Essential hypertension; cerebral hemorrhage.
Salb, John A. (M)	64	Aug.	18	Indianapolis	Arteriosclerotic heart disease.
Brubaker, Elmer H. (H)	80	Aug.	22	Indianapolis	Congestive heart failure.
Reiff, Christian W. (R)	73	Aug.	23	Idaville	Cerebral thrombosis. Cerebral arteriosclerosis.
Martin, William J. (M)	79	Aug.	24	Kokomo	Cerebral hemorrhage.
Glick, Orval E. (M)	75	Aug.	25	Kentland	Cerebral hemorrhage.
Winstandley, William C. (H)	77	Aug.	28	New Albany	Coronary occlusion.
Heysell, Norman W. (M)	45	Sept.	6	Fort Wayne	Pulmonary tuberculosis; hypertension.
Sullivan, Thomas L. (M)	63	Sept.	6	Indianapolis	Cerebral hemorrhage.
Knapp, Adam B. (H.R.)	87	Sept.	8	Vincennes	Heart disease.
Hazel, James T. (R.H.)	80	Sept.	18	Freedom	Diabetes mellitus.
Hurt, Paul T. (M)	62	Sept.	23	Indianapolis	Coronary disease.
Bannon, Freeman R. (R)	62	Sept.	28	Kokomo	
Kellough, Aimee R. (M)	71	Sept.	29	Michigan City	Cerebral hemorrhage.
Stutsville, Stephen W. (R)	78	Sept.	30	Grandview	Coronary thrombosis; coronary sclerosis.
Healy, William F. (M)	45	Oct.	7	Evansville	Hypertensive cardiovascular disease.
Sims, Stephen B. (R) (H)	88	Oct.	13	Frankfort	Coronary occlusion; myocardial degeneration; arteriosclerosis.

Name	Age	Date of Death 1949		Address	Cause of Death
Holland Emory E. (M)	65	Oct.	13	Richmond	Carcinoma of the larynx.
Horton, Jack H.	29	Oct.	20	Bloomington	Overdose of barbital; suicide.
Stephenson, Lewis E. (M)	70	Oct.	24	Michigan City	Coronary occlusion.
Davidson, William R. (M)	74	Oct.	29	Evansville	Carcinoma.
Moore, Harvey A.	72	Nov.	6	Indianapolis	Heart block; diabetes mellitus.
Buckles, Herbert L.	65	Nov.	24	Hartford City	Adenocarcinoma of the colon.
Aker, Charles L. (M)	56	Dec.	2	Greencastle	Gunshot, suicide.
Blood, Roscoe P. (R)	69	Dec.	2	Hebron	Carcinoma of the liver.
Sanders, Ira M. (H)	79	Dec.	9	Greensburg	Coronary thrombosis.
Oldham, Harry N. (R)	71	Dec.	14	Hartsville	Arteriosclerotic gangrene of left leg.
Barnard, Pliny C. (H)	81	Dec.	15	Parker	Arteriosclerotic heart disease; senility.
Hinkle, James S.	90	Dec.	19	Martinsville	Cerebral arteriosclerosis.
Lukenbill, Emery D. (M)	55	Dec.	19	Indianapolis	Coronary occlusion.
Titus, Phillip S. (M)	66	Dec.	21	Fort Wayne	Adenocarcinoma of the prostate.
Hartsock, William B.	71	Dec.	29	Indianapolis	Carcinoma of the left lung.
Hughes, James E. (M)	71	Dec.	31	Indianapolis	Cerebral hemorrhage; cerebral arteriosclerosis; hypertension.

A.M.A. ADVERTISING PROGRAM

The American Medical Association, by unanimous action of its Board of Trustees and Campaign Coordinating Committee, has given the final "go ahead" signal for a nation-wide advertising program which will include three principal media—newspapers, magazines and radio—as a new phase of its National Education Campaign in behalf of Voluntary Health Insurance and against socialized medicine.

A total advertising budget of $1,110,000 has been approved by the A.M.A. Board of Trustees, it was announced, with $560,000 allocated to newspapers, $300,000 to radio and $250,000 to National magazines. The entire campaign is scheduled for October.

The newspaper advertising schedule calls for blanket coverage of every bona fide daily and weekly newspaper in the United States—approximately 11,000, in total—and the copy is scheduled to run during the week of October 8. Newspapers in the territories of Hawaii and Alaska will be included in the schedule. The space reservation will approximate 70 inches (probably a 5x14) in all papers.

About 30 of the leading national magazines, and a score of advertising trade publications, will be included in the magazine ad program.

The radio advertising program calls for an intensive "spot announcement" campaign, utilizing time on some 300 radio stations, covering every state and Hawaii and Alaska.

Some of the major factors involved in the decision to launch the program were as follows:

1. In order to relieve the medical profession of any necessity for a continuing, exhaustive campaign for survival, it is imperative to find a way to bring the issue of Government-controlled medicine to a public conclusion.

2. The most desirable action possible, naturally, would be a vote in Congress—and that conclusion we are thoroughly prepared for, and would welcome.

3. However, the issue will not be permitted by its sponsors to emerge in this Congress, and we are forced to find other means to solidify medicine's position.

4. Medicine, in its national campaign, has won the support of the greatest cross-section of public sentiment ever amassed on a controversial public issue in this country. Medicine and its allies have proved to millions of people and to thousands of publicly responsible organizations that the problems of medical service, care and cost can be solved under the voluntary system, without Federal controls.

The American Medical Association is embarking on a nation-wide advertising program for two reasons. First, it is determined to aid in every way possible in increasing the availability of good medical care to the American people through the medium of Voluntary Health Insurance. In that respect, the advertising copy will be designed to make the American people "health insurance conscious" and to encourage the extension and development of prepaid medical and hospital care as a means of taking the economic shock out of illness. Second, American medicine is determined to alert the American people to the danger of socialized medicine and to the threatening trend toward State Socialism in this country.

The ad copy, in part, will be designed to sell a commodity, Voluntary Health Insurance, but not any particular brand or plan. The individual will be encouraged to secure sound coverage in the plan which he feels best suits his individual needs. In its second aspect, the ad copy will be used to mobilize public opinion in support of a basic American ideal—the principle of individual freedom, as opposed to the alien philosophy of a Government-regimented economy.

ORDER YOUR TICKETS FOR THE 1950 INSTRUCTIONAL COURSE NOW!

The schedule of classes for the 1950 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at French Lick Springs Hotel, French Lick, is now complete. All classes are on Monday, September 25, 1950.

Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is $1.00 per class with a maximum charge of $3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now! Classes are filled early!

INSTRUCTIONAL COURSE SCHEDULE

Hrs.	Room A	Room B	Room C	Room D	Room E	Room F
11 to 12	Psychological Management of Patients Dr. K. I. Jeffries Course 1	Diagnosis and Treatment of Respiratory Diseases Dr. R. S. Henry Course 2	Pediatric Problems Dr. R. Hippensteel Course 3	Ear, Nose and Throat Problems Dr. Bert Ellis Course 4	The Backache Problem Dr. C. F. Thompson Course 5	Problems of Hypertension Dr. W. A. Shullenberger Course 6
NOON RECESS						
1 to 2	Bedside and Office Diagnosis of Cardiac and Vascular Problems Dr. A. T. Stone Course 7	Anemia and Blood Dyscrasias Dr. Philip Kurtz Course 8	Infant Feeding Problems Dr. S. A. Kauffman Course 9	Office Management of Anorectal Diseases Dr. J. W. Ricketts Course 10	Minor Home, Farm and Factory Emergencies Dr. A. K. Harcourt Course 11	Office Diagnosis and Treatment of Common Genitourinary Conditions Dr. John Hendricks Course 12
2 to 3	The Demonstration of a Diagnostic Neurological Examination Dr. E. Vernon Hahn Course 13	Bedside and Office Diagnosis of Cardiac and Vascular Problems Dr. E. P. Tischer Course 14	Problems in the Management of Rheumatic Fever Dr. M. Winters Course 15	The Diagnosis and Treatment of Common Skin Diseases Dr. Don E. Kelly Course 16	Corns, Bunions and Painful Feet Dr. G. W. Batman Course 17	Diagnosis and Management of Common Gynecological Conditions Dr. T. B. Noble, Jr. Course 18
3 to 4	The Demonstration of A Diagnostic Physical Examination Dr. J. O. Ritchey Course 19	The Management of Diabetes Mellitus Dr. O. E. Carter Course 20	Obstetrical Emergencies Dr. G. W. Gustafson Course 21	The Newer Drugs Dr. R. A. Solomon Course 22	Arthritis Dr. W. M. Dugan Course 23	The Management of the Menopause Syndrome Dr. Floyd S. Romberger, Jr. Course 24
4 to 5	The Headache Problem Dr. John H. Greist Course 25	The Examination and Management of Cancerphobia Dr. Ben B. Moore Course 26	Impotence and Infertility Dr. Ernest Rupel Dr. John Spahr Course 27	The Diagnosis and Treatment of Common Skin Diseases Dr. F. Gastineau Course 28	The Treatment of Colitis and Constipation Dr. A. G. Funkhouser Course 29	The Management of Problems of the Elderly Dr. Wm. E. King Course 30

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APPLICATION BLANK

Instructional Course Committee,
c/o Gordon W. Batman, M.D.,
723 Hume Mansur Building,
Indianapolis 4, Indiana.

Enclosed find check for $1.00; $2.00; $3.00. Please reserve tickets for the following Instructional Courses:

	11:00 A.M.	1:00 P.M.	2:00 P.M.	3:00 P.M.	4:00 P.M.
First choices	No.:	No.:	No.:	No.:	No.:
Second choices	No.:	No.:	No.:	No.:	No.:

(Insert course numbers plainly, please.)

I will pick up my tickets at the Registration Desk, September 25, 1950.

Signed: ..... M.D.

Address: .....

Just in Case You May Forget

1950 Annual Session

Indiana State Medical Association

FRENCH LICK

Sunday, Monday and Tuesday
September 25, 26 and 27

Write Direct to the Hotel for Your Reservation!

HOTELS AND RATES

French Lick Springs Hotel, French Lick, Indiana
(American Plan)

Single room with bath.....$14.00 per day
Double room with bath.....$12.00 per day per person
Double room with lavatory and toilet .....$10.00 per day per person
Double room with running water .....$ 9.00 per day per person
Parlors .....$12.00 per day

For those persons staying outside the hotel the meal rate will be: Breakfast, $1.50; luncheon, $2.00, and dinner, $3.00, including tickets for the banquet Wednesday night, September 27.

Check-out hours are 11:00 a.m. and 4:00 p.m.

Grand Hotel, French Lick, Indiana
(European Plan)

Rooms with bath on halls—
Double $3.00, $2.50, $2.00
Single $2.00, $1.50, $1.00

Claxton House, French Lick, Indiana
(European Plan)

Rooms with bath on halls—
Double $2.00
Single $1.50

West Baden Springs Hotel, West Baden, Indiana*
(European Plan)

Double room with bath.....$5.00 double; $3.00 single
Double room with toilet (no bath) .....$4.00 double; $2.50 single
Double room with running water only .....$3.50 double; $2.00 single

Be sure to specify type of accommodations, and time of arrival and departure.

Schedule of Events

MONDAY, SEPTEMBER 25

Instructional courses, Council and House of Delegates meetings, golf and trap shoot, party for women at night, and the big stag jamboree.

TUESDAY, SEPTEMBER 26

Scientific papers, morning and afternoon. Dancing at night to music of name band.

WEDNESDAY, SEPTEMBER 27

Scientific papers morning and afternoon. Final meeting of Council and House of Delegates. Annual dinner, with nationally-known humorist as principal speaker.

* West Baden Springs is one mile from French Lick

News Notes

GENERAL PRACTICE RESIDENCY

The Methodist Hospital, Indianapolis, is inaugurating a General Practice Residency, and invites inquiries from interns, residents and practitioners. The term of the residency is one year. The service will include medicine, surgery and obstetrics. Inquiries may be addressed to Robert E. Neff, Superintendent.

REGULAR CORPS EXAMINATION FOR MEDICAL OFFICERS

A competitive examination for appointment of Medical Officers in the Regular Corps of the United States Public Health Service will be held on October 9, 10 and 11, 1950. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received no later than September 11, 1950. Application forms and additional information may be obtained by writing to the Surgeon General, United States Public Health Service, Federal Security Agency, Washington 25, D. C. Attention: Division of Commissioned Officers.

UNORDERED MERCHANDISE

The National Better Business Bureau considers the sending of merchandise without an order to be an unfair business practice and recommends against its use. They advise the public that recipients of unordered merchandise are *not* obliged to acknowledge its receipt; to return it; to pay for it unless used; to give it particular care; to keep it beyond a reasonable period of time.

Recipients of unordered merchandise *are* obliged to surrender it to the shipper, or his agent, if called for in person within a reasonable period of time—in which case the recipient may demand the payment of storage charges before relinquishing it.

The Post Office Department does not knowingly permit the mails to be used for shipping unordered goods C.O.D. The postal regulation governing this matter states:

> "Collect-on-delivery shipments shall in all cases be based on bona fide orders for the contents of the article or be in conformity with agreements between senders and addressees."

The most practical way to curb the unordered merchandise nuisance is to make it unprofitable. This can be done effectively, the Bureau advises recipients, by holding such goods for a few months, at which time liability ends.

A.M.A. RELEASES FILM DIRECTORY

Reviews of 225 medical and health films are now available in booklet form from the American Medical Association.

The Committee on Medical Motion Pictures of the A.M.A. has recently revised its booklet entitled "Reviews of Medical Motion Pictures," and a brief description and evaluation of each motion picture is included. Copies are available at a cost of twenty-five cents each from the Order Department of the American Medical Association.

COURSE IN POSTGRADUATE GASTROENTEROLOGY

The National Gastroenterological Association announces that its course in Postgraduate Gastroenterology will be given at the Hotel Statler in New York City on October 12, 13, 14, 1950.

The course, which will again be under the personal direction of Dr. Owen H. Wangensteen, Professor of Surgery, University of Minnesota Medical School, will cover the following subjects: Diseases of the Mouth; Diseases of the Esophagus; Peptic Ulcer Diseases of the Stomach; Diseases of the Pancreas; Cholecystic Disease; Psychosomatic Aspects of Gastrointestinal Disease; Diseases of the Liver; Diseases of the Colon and Rectum, and other miscellaneous subjects including Pathology and Physiology, Radiology, Gastroscopy, et cetera.

For further information and enrollment write to the National Gastroenterological Association, Dept. GSJ, 1819 Broadway, New York 23, N. Y.

PLASTIC SURGERY AWARD

The Foundation of the American Society of Plastic and Reconstructive Surgery offers as its 1950 award $500 (first prize of $300, second prize of $200) and a Certificate of Merit, for essays on some original unpublished subject in plastic surgery.

Competition shall be limited to residents in plastic surgery of recognized hospitals and to plastic surgeons who have been in such specific practice for not more than five years.

The first prize essay will appear on the program of the forthcoming annual meeting of the American Society of Plastic and Reconstructive Surgery, to be held in Mexico City, November 27 to 29, 1950. Essays must be in before August 15, 1950.

For full particulars write the Secretary, Dr. Clarence R. Straatsma, 66 East 79th Street, New York, N. Y.

AWARD FOR OUTSTANDING RESEARCH IN THE FIELD OF INFERTILITY

The American Society for the Study of Sterility offers an annual award of $1,000, known as the Ortho Award, for an outstanding contribution to the subject of infertility and sterility. Competition is open to those in clinical practice as well as individuals whose work is restricted to research in the basic sciences. Essays submitted for the 1951 contest must be received not later than March 1, 1951. The Prize Essay will appear on the program of the 1951 meeting of the Society. For full particulars, address The American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield, Mass.

The American Congress of Physical Medicine will hold its twenty-eighth annual scientific and clinical session August 28, 29, 30, 31 and September 1, 1950 inclusive, at the Hotel Statler, Boston, Massachusetts. Scientific and clinical sessions will be given on the days of August 28, 29, 30, 31 and September 1, 1950. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction seminars will be held August 28, 29, 30 and 31. These seminars will be offered in two groups. One set of ten lectures will consist of basic subjects and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to therapists who are registered with the American Registry of Physical Therapy Technicians or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

The **First International Congress on Diseases of the Chest** will be held September 17 to 22, 1950, at the Carlo Forlanini Institute, in Rome, Italy. One hundred subjects will be presented by more than 100 speakers, from South America, Mexico, Italy, France, Philippine Islands, Greece, England, Scotland, Austria, Portugal, Switzerland, Lebanon, Cuba, Israel, Australia, Belgium, Turkey, Egypt, Norway, Spain, India, and the United States. For further information, contact Chevalier L. Jackson, M.D., chairman, Council on International Affairs, American College of Chest Physicians, Philadelphia, Pa.

The eighteenth annual meeting of **The Central Association of Obstetricians and Gynecologists** will be held September 21, 22 and 23, 1950, at the Hotel Schroeder, in Milwaukee.

REPORT INCREASE OF 2,266 IN PHYSICIAN POPULATION FOR 1949

The net increase in the number of physicians in the United States and its territories and possessions in 1949 was 2,266, according to the 48th Annual Medical Licensure Report of the American Medical Association's Council on Medical Education and Hospitals.

These official figures indicate that last year 5,866 physicians were licensed for the first time, and thus represent the gross additions to the profession for that year. In 1949 there were 3,600 deaths of physicians reported to the offices of the American Medical Association.

The greatest number of physicians licensed for the first time in any one state was 973 in New York. California had more than 500 first licentiates and Pennsylvania more than 400.

During the year there were 12,181 licenses to practice medicine issued by the medical examining boards of the 48 states, the District of Columbia and the territories and possessions.

Fourteen state medical licensing boards have accepted a list of high standard foreign medical schools compiled by the American Medical Association's Council on Medical Education and Hospitals and the Executive Council of the Association of American Medical Colleges. These state boards will use the list as a guide to licensing foreign-trained physicians. Fifteen states report that their boards have not met since the list was released but that the list will be given consideration.

The list contains the names of 38 schools in nine foreign countries. It was issued at the 46th Annual Congress on Medical Education and Licensure held in Chicago in February of this year. The list is not final and it will be supplemented as information is compiled for other schools.

Nearly a hundred million dollars, representing more than 88 percent of income, was paid to hospitals by the voluntary, nonprofit **Blue Cross Plans** for care of members during the first quarter of 1950, Richard M. Jones, Chicago, director, Blue Cross Commission of the American Hospital Association, has announced.

From a total income of $109,801,301, the 90 Blue Cross Plans of the United States and Canada paid $96,989,972 for members' care and used only $9,184,564 (8.37 percent) for operating expenses.

There are more than 38,000,000 persons enrolled in the Blue Cross Plans in the United States and Canada, representing more than 24 percent of the United States population and 21 percent of the Canadian people.

The life insurance companies of the United States and Canada will give $670,000 to medical schools and other research centers during 1950 for the study of heart disease and the training of research scientists. The awards were approved at the annual meeting of the Life Insurance Medical Research Fund, which was held in New York City in May, and bring to $3,200,000 the total amount of money given by the Fund since it was organized late in 1945. A student research fellowship has been awarded to Jack N. Rinker, of Lafayette, Indiana, to work under the supervision of Dr. Henry Koffler at Purdue University, Lafayette.

A Medical Assistants' Association has been organized in Evansville. Officers were installed at the first dinner meeting, which was held at the Hotel Vendome on May 9. They are: Miss Wanda Lee Marx, president; Miss Sophia L. Green, vice-president; Mrs. Mary D. Dickerson, secretary; and Mrs. Elizabeth R. DeGroots, treasurer.

Excerpt from a letter received by **Dr. Simon Reisler**, of Indianapolis, from a former employee who is now in England: "Doctor, this socialized medicine here in Britain is the craziest thing. A man orders a pair of glasses after having his eyes tested—19 months later he receives the glasses, by which time, of course, his eyesight has changed and the things are useless. It is the same with false teeth, only it takes two years to get them instead of 19 months. Of course, the doctors' offices are crowded, with no one getting individual attention. I have thought so much about your 'Subjectivity and Objectivity' since being here. I truly believe that a complete medical examination is unheard of over here. I cannot honestly imagine how the American people would fare under a similar system, simply because they have such a high standard where medicine is concerned."

Dr. Thad T. Richardson, of Indianapolis, has resumed the general practice of medicine after completing two years of active duty with the Air Force. He is associated with **Dr. O. C. Neier**, at 5508 East Washington Street, in Indianapolis. Doctor Richardson is a graduate of Indiana University School of Medicine, and served his internship at Indianapolis General Hospital.

Dr. A. J. Van Winkle, of Valparaiso, has been awarded a fellowship in the International Aero Medical Society at that organization's recent meeting in Chicago.

The offices of **Drs. Beeler, Collins and Loehr**, at 712 Hume Mansur Building, in Indianapolis, will be closed from July 3 to July 24.

The Class of 1935 of Indiana University School of Medicine will hold a reunion at noon on Wednesday, September 27, in Parlors A and B at French Lick Springs Hotel, during the state convention.

Dr. John I. Waller, of Indianapolis, has moved to Halstead, Kansas, to become the head of the Department of Urology at the Hertzler Clinic there.

Dr. Victor F. Albright, of New Castle, has moved to Winchester, Virginia, where he is associated in surgery with **Dr. Leslie Bell** of that city. Doctor Albright is a graduate of Indiana University School of Medicine, and has practiced in New Castle for the past eighteen months.

Dr. Jackson P. Birge has been appointed the first full-time health commissioner of Elkhart County. He has been serving as head of the northwest branch office of the Indiana State Board of Health at LaPorte.

Dr. Irvin L. Zeiger, of Morocco, has moved to 3201 Mishawaka Avenue, South Bend, where he will be engaged in the general practice of medicine. His practice in Morocco has been assumed by **Dr. J. W. Donovan**, a graduate of New York Medical College.

Dr. Ambrose C. Estes has opened an office for the practice of surgery at 300½ East Kirkwood Street, in Bloomington. He is a 1941 graduate of the University of Pennsylvania, and served his internship at the Indiana University Medical Center. He also served a residency in pathology there. Doctor Estes spent four years active duty with the Army Medical Corps, following which he served as resident surgeon at the Scott and White Hospital at Temple, Texas.

Dr. Claude A. Hendrix, Jr., of Franklin, has opened an office in Waveland for the practice of medicine. He is a graduate of the Louisville School of Medicine, and interned at the United States Naval Hospital in San Diego, California. He also served in the medical division of the Navy for three years.

On May 23 **Dr. C. O. McCormick**, of Indianapolis, addressed the Illinois State Obstetrical and Gynecological Society at Springfield, Illinois, and on June 19 he spoke before the Maine State Medical Association, at Portland, Maine.

Indiana University News Notes

ALUMNI DAY AT THE I.U. SCHOOL OF MEDICINE—MAY 10, 1950

Physicians from 58 Hoosier communities, 13 other states and the District of Columbia were registered. Attendance represented a wider area than in the previous two meetings.

The program this year contained fewer scientific presentations than in the past, with additional time given for informal class and group reunions during the day — especially during the picnic luncheon which was served on the lawn in front of Rotary Convalescent Home at noon. The use of decorated serving booths, manned by members of the dietary staff, added to the colorful setting.

A scientific address was given by Dr. David G. Pugh, '32, now with the Department of Radiology, Mayo Clinic, who discussed, "Early Diagnosis of Spinal Arthritis."

The second formal address of the day was given by Rear Admiral Morton D. Willcutts, '16, National Naval Medical Center, Bethesda, Maryland, who spoke on "Mass Casualties," in a review of potential radiological and bacteriological warfare.

The third speaker was Dr. John D. VanNuys, dean of the School of Medicine, who reviewed the past year and discussed plans for the further development of the Medical Center. At the conclusion of his remarks Dean VanNuys was presented with a silver desk smoking set by the senior class.

Oldest physicians, in point of years of practice, registered included:

Class of 1894—L. R. Knepple, Kokomo.
Class of 1901—Rose J. Piscator Buttz, Indianapolis.
Class of 1904—James Hilgenberg, Pesotum, Illinois, and
L. W. Tennant, Fort Wayne.

The business session of the Alumni group resulted in the establishment of a permanent organization to hold annual meetings, and the installation of officers elected by mail ballot prior to the meeting. Installed were:

President—Merrill S. Davis, '14, Marion.
Vice-President—Alvin Newman, '23, Evansville.
Secretary—J. Neill Garber, '32, Indianapolis.
Treasurer—Mary Alice Norris, '37, Indianapolis.
Historian—Frank Forry, '23, Indianapolis.

Also installed were 12 members of the Alumni Council, elected by mail ballot and designated to serve for one, two or three years. Members of the council include—

One year—

Seth Ellis, '25, Anderson.
James Engeler, '37, Lafayette.
Maurice Glock, '34, Fort Wayne.
Marshall Hewitt, '37, South Bend.

Two years—

L. D. Bibler, '25, Indianapolis.
W. C. Moore, '14, Muncie.
Robert Oliphant, '36, Terre Haute.
Ben R. Ross, '25, Bloomington.

Three years—

Arlie R. Barnes, '19, Rochester, Minnesota.
Cyrus J. Clark, '23, Indianapolis.
J. O. Ritchey, '18, Indianapolis.
Karl R. Ruddell, '11, Indianapolis.

This year the wives of alumni and staff were invited to participate in the luncheon and to attend a special program following. This program included a talk on the operation of the Child Guidance Clinic, a visit to the Clinic and tours of the Riley Hospital and Rotary Convalescent Home, followed by a tea at the Ball Residence.

The final event of the day was the annual dinner, attended by alumni, staff and medical students, with their wives, at the Athenaeum. President Merrill S. Davis presided at the dinner, and introduced Judge Ora L. Wildermuth, Gary, president of the Board of Trustees of the University, who was the only speaker.

The schedule for the Instructional Course Program will be found on page 621

A.M.A. WASHINGTON OFFICE NEWS

Some Census Enumerators "Reducing Physicians" Work Week. We have received a few reports of census enumerators telling physicians that *60 hours* is the *maximum* work-week that may be reported. If this practice is widespread, it could mean a *gross under-estimate* of the average physician's hours of work in the final, official tabulation. Where enumerators are following this practice they are acting in violation of standing census regulations. Lowell Galt, head of the Census Bureau's field division, said enumerators have been ordered to report *all work* done the previous week, when the form calls for such data. In professional work, he said this means total hours spent at the profession, not merely time spent in actual consultation or treatment. Mr. Galt said the Bureau is anxious to make corrections in every case where enumerators have *arbitrarily reduced the reported work week.* District Census superintendents should be contacted, or if the district office has been closed out, Mr. Galt's office in Suitland, Md.

FDA Asks Help In Locating Drug Shipments. Food and Drug Administration is asking for help in locating *Oxylin tablets* of which the manufacturer has no shipping record. The manufacturer, Drexel Laboratories and Louis E. Evon of Drexel Hill and Upper Darby, Pa., is attempting to round up all tablets put into trade channels, but has no trace of about *18,000* of them. FDA announced that Oxylin, an uncoated tablet, has a "considerable amount" of *boric acid,* which might prove poisonous to sensitive individuals. Most recovered shipments were located in the eastern states.

Democratic National Committee Distributing Health Plan Pamphlet. A few weeks ago CAPITOL CLINIC reported that a new pamphlet on President Truman's health plan was being prepared. It is now being distributed by the *Democratic National Committee.* The pamphlet ("Better Medical Care That You Can Afford") is small (four by five inches), printed in black and green, with simple line drawings on 31 of the 32 pages. Essentially, it is an overly-condensed argument for national compulsory health insurance. The whole complicated subject is disposed of in *1,000 words or less.* The possibility that there might be honest and informed objection to compulsory national health insurance is dismissed in these two sentences: "Why do some people oppose it? Either because of self-interest or because they don't understand it."

Reorganization Plan Won't Die On Adjournment: Becomes Law If Not Voted Down. Regarding Reorganization *Plan No. 27,* which would make FSA into a cabinet-rank Department of Health, Education and Security, it is important to keep this fact in mind for the *next two months:* Unlike usual *legislation,* this plan will not die a natural death should Congress adjourn without acting upon it. (There is one exception: a possibility of Congress adjourning before July 31. If this should happen, the plan would automatically die.) If Congress takes no action on this plan, yet stays in session through July 31, Mr. Truman *automatically* will be authorized to set up the new department. Ignoring this proposal will not defeat it—the only way to stop it is for either Senate or House to disapprove it by a majority vote of *all* members, not just all members present on the *day of the vote.*

WHO Budget Again Pegs U. S. Contribution Beyond Authorized Limit. Action by World Health Organization's finance committee again has scheduled U. S. for a contribution *in excess* of the $1,910,000 ceiling *set by Congress.* WHO reduced U. S. share of total budget from 36 to 35 percent for next year, but with a budget of $7,100,000 this is still approximately *half a million more than Congress has authorized.* House Rules Committee has not acted on a bill which would boost the authorized U. S. contribution to $2,500,000.

Committee Told That A.M.A. Refused To Work With Real Estate Lobby. Washington's lobbying investigation opened with three days of testimony by representatives of real estate interests. The House Committee concentrated on Herbert U. Nelson, executive vice president, National Association of Real Estate Boards. He explained how his organization operated, and described an informal group of 18 associations which met with it at luncheon meetings. Mr. Nelson told how he attempted to set up *"a broad cooperative front for private enterprise,"* but failed. A letter by Mr. Nelson on this subject was read to the committee. It said in part: "I went to the offices of the AMA and talked to them about our working together. There was nothing doing." Later, Representative Clyde Doyle (Dem., Calif.) wanted to know: *"Why not stay in your own field?* Why ask AMA to join you? Do you think the field of medicine is very close to real estate?" Mr. Nelson replied that "the medical argument has been used in public housing," and referred again to his abortive efforts to set up a "broad front" of organizations with kindred interest. Representative Charles A. Halleck (Ind.), Republican leader, observed "I wouldn't object to seeing some of the folks who are against socialization in their own field taking an interest in encroachments in other fields, because it might, from my standpoint, be the best course for the country." The investigation continues.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

May 21, 1950

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D.; W. U. Kennedy, M.D.; A. F. Weyerbacher, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Guests: J. T. Oliphant, M.D.; L. E. Burney, M.D., secretary, State Board of Health; Norman R. Booher, M.D.; Dan E. Talbott, M.D.; Maurice O. Hunt, administrator, State Department of Public Welfare, and Glen Ward Lee, M.D., chairman, Committee on Veterans Affairs and Rehabilitation.

Membership Report

Number of members May 20, 1950	3,476*
Number of members May 20, 1949	3,661
Loss over last year	185
Number of members December 31, 1949	3,758

* Includes 21 in military service; 109 $10 members; 204 senior members.

Treasurer's Office

The request of a senior in the Indiana University School of Medicine for a loan was declined, on motion of Drs. Ellison and Weyerbacher.

1950 Annual Session, French Lick, September 25, 26 and 27, 1950

On motion of Drs. Black and Clark $50 was appropriated to purchase a painting by a Brown county artist for the general practitioner of the year award, and the treasurer was directed to make the selection.

On motion of Drs. Clark and Ellison, the executive secretary was directed to write a letter to Dr. Elmer L. Henderson, president-elect of the American Medical Association, inviting him to attend the annual banquet.

Statements of receipts and expenditures for April for the association and THE JOURNAL were approved.

Legislative Matters

National

After a letter from Dr. James Doenges, asking certain questions on policies of the association, was read, the chairman of the Executive Committee and the executive secretary were directed to prepare an answer, on motion of Drs. Clark and Black.

On motion of Drs. Clark and Weyerbacher, the question of renewing the subscription to the Washington Report on the Medical Sciences was left to the co-chairmen of the Committee on Public Policy and Legislation.

Local

The executive secretary was directed to contact the American Medical Association to see if it will issue a folder explaining reasons why chiropractors should not be added to the medical staff of the Veterans Administration and assist in convincing the 14,000 delegates to the American Legion convention in San Francisco this fall that this would be an unwise procedure.

A letter from the executive secretary of the Indianapolis Medical Society relating the success of candidates slated by the society in the recent primary election was read.

A.M.A. Campaign Coordinating Committee

The field secretary reported on the resolution and advertising campaign. On motion of Drs. Clark and Ellison, the recommendation was made to the Indiana A.M.A. Campaign Coordinating Committee that it consider increasing the size of the advertisements to make them more effective.

Organization Matters

Nominations for Associate Fellowship in A.M.A. Names of eighteen members who are eligible to Associate Fellowship in the A.M.A. were approved for submission to the House of Delegates of the American Medical Association on motion of Drs. Kennedy and Clark.

The invitation of the Associated State Postgraduate Committee for the association to become a member at an annual fee of $25 was tabled, on motion of Drs. Kennedy and Ellison.

The executive secretary read a report from Dr. George M. Brother, Director of Preventive Medicine, Indiana State Board of Health, regarding the distribution of penicillin to private physicians for use in treating indigent patients suffering from venereal disease. Dr. L. E. Burney, state health commissioner, who was present, implemented Dr. Brother's report with explanatory remarks. No action was taken.

Letter from the chairman of the Council of the Missouri State Medical Association, asking what

(Continued on Page 694)

Membership Roster

INDIANA STATE MEDICAL ASSOCIATION

Following is a list of the members of the Indiana State Medical Association, including the names of all those who were members on June 1, 1950. Membership established after that date could not be included in this issue of THE JOURNAL. Members are listed in the county in which they hold their membership.

The letter (H) following a name indicates that the physician is an honorary member of his local society and of the Indiana State Medical Association.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 1017 Hume Mansur Building, Indianapolis 4, Indiana. The cooperation of members is urgently requested.

ALPHABETICAL LIST OF MEMBERS

A

Name	City	County
Aagesen, J. W.	Anderson	Madison
Abel, J. A.	South Bend	St. Joseph
Abell, Charles F.	Marion	Grant
Abreu, Benedict E.	Indianapolis	Marion
Acher, Robert P.	Greensburg	Decatur
Acker, Robert B.	South Bend	St. Joseph
Acos, James C.	East Chicago	Lake
Acre, R. R.	Evansville	Vanderburgh
Adair, Samuel L.	Jeffersonville	Clark
Adair, Wm. K.	Crothersville	Jackson
Adams, J. R.	Ft. Wayne	Allen
Adams, Max R.	Flora	Carroll
Adams, William B.	Muncie	Delaware-Blackford
Adamski, Michael S.	Logansport	Cass
Ade, C. H.	Lafayette	Tippecanoe
Ade, Mary	Lafayette	Tippecanoe
Adkins, H. C.	Indianapolis	Marion
Adkins, Onan C.	Indianapolis	Marion
Adler, David L.	Columbus	Bartholomew-Brown
Adler, Edmund R.	Dyer	Lake
Adler, Raymond N.	Evansville	Vanderburgh
Adney, Frank B., Jr.	Indianapolis	Marion
Agee, Ernest B., Jr.	Terre Haute	Vigo
Aiken, Arthur F.	Ft. Wayne	Allen
Aiken, N. E.	Ft. Wayne	Allen
Ake, Loren	Richmond	Wayne-Union
Albertson, F. P.	Indianapolis	Marion
Albrecht, J. R.	Vincennes	Knox
Aldrich, Harry	Indianapolis	Marion
Aldrich, Howard	Indianapolis	Marion
Aldridge, J. W.	Covington	Fountain-Warren
Alexander, Ezra D.	Indianapolis	Marion
Alexander, H. H.	Princeton	Gibson
Alexander, J. E.	Evansville	Vanderburgh
Alexander, O. O.	Terre Haute	Vigo
Alexander, P. M.	Martinsville	Morgan
Alford, James	Hamilton	Steuben
Allegretti, Michael	Hammond	Lake
Allen, Fred K.	Salem	Washington
Allen, Hubert E.	Richmond	Wayne-Union
Allen, J. L. (H)	Greenfield	Hancock
Allen, L. Howard	Bedford	Lawrence
Allen, Orris T.	Terre Haute	Vigo
Allen, Robert T.	Richmond	Wayne-Union
Almquist, C. O.	Gary	Lake
Altier, W. H.	Fowler	Benton
Alvey, Charles R.	Muncie	Delaware-Blackford
Alvis, Edmond O.	Indianapolis	Marion
Alward, John Haney	Akron, Ohio	Marion
Ambrose, J. C.	Noblesville	Hamilton
Ames, George (H)	Eaton	Delaware-Blackford
Amick, Charles L.	Wakarusa	Elkhart
Amos, R. L.	New Castle	Henry
Amstutz, Henry C.	Goshen	Elkhart
Amy, W. E.	Corydon	Harrison
Anderson, Dwight	Evansville	Vanderburgh
Anderson, R. J.	Indianapolis	Marion
Anderson, R. M.	Vincennes	Knox
Anderson, Walter C.	Terre Haute	Vigo
Anderson, Wendell C.	Indianapolis	Marion
Annis, Homer B.	Bluffton	Wells
Antes, Earl H.	Evansville	Vanderburgh
Anthoulis, George D.	Gary	Lake
Appel, Richard H.	Indianapolis	Marion
Applegate, Albert E.	Frankfort	Clinton
Arbeiter, Herbert I.	Hammond	Lake
Arbogast, J. L.	Indianapolis	Marion
Arbogast, Paul B.	Vincennes	Knox
Arbuckle, Russell	Indianapolis	Marion
Arbuckle, Wm. E.	Indianapolis	Marion
Arisman, R. K.	South Bend	St. Joseph
Arlook, Theodore D.	Elkhart	Elkhart
Armington, C. L.	Anderson	Madison
Armington, John C.	Anderson	Madison
Armington, Robert	Anderson	Madison
Armstrong, T. D.	Michigan City	La Porte
Arnett, A. C.	Lafayette	Tippecanoe
Arnold, Aaron L.	Indianapolis	Marion
Arnold, M. F.	East Chicago	Lake
Arnold, Robert D.	Indianapolis	Marion
Aronson, Sidney S.	Indianapolis	Marion
Arrowsmith, James L.	Hammond	Lake
Arthur, H. M. (H)	Hazelton	Gibson
Asbury, W. D.	Terre Haute	Vigo
Ash, H. H.	W. Lafayette	Tippecanoe

Name	City	County
Asher, E. O.	New Augusta	Marion
Asher, James W.	New Augusta	Marion
Ashworth, L. N.	Connersville	Fayette-Franklin
Atkins, C. C.	Rushville	Rush
Atkinson, C. W.	Boswell	Benton
Aucreman, C. J.	Bluffton	Wells
Ault, Roy, Jr.	Terre Haute	Vigo
Austin, Eugene W.	Evansville	Vanderburgh
Austin, F. H. (H)	Bloomington	Owen-Monroe
Austin, M. A.	Anderson	Madison
Austin, R. P.	Bedford	Lawrence
Ayres, Kenneth D.	Anderson	Madison
Ayres, W. W.	Marion	Grant

B

Name	City	County
Babb, Forrest J.	Stockwell	Tippecanoe
Bachmann, Arnold J.	Indianapolis	Marion
Backer, Henry G.	Ferdinand	Dubois
Badders, A. C.	Portland	Jay
Bahr, Max A.	Indianapolis	Marion
Bailey, Edwin B.	Linton	Greene
Bailey, E. W.	Logansport	Cass
Bailey, L. S.	Zionsville	Boone
Bailey, Paul P.	Fort Wayne	Allen
Bailey, Wm. A. (H)	Vincennes	Knox
Baitinger, H. M.	Gary	Lake
Bakemeier, O. H.	Indianapolis	Marion
Baker, A. M.	New Albany	Floyd
Baker, G. D.	Crandall	Harrison
Baker, Herman	Evansville	Vanderburgh
Baker, J. S.	Evansville	Vanderburgh
Baker, Leslie M.	Aurora	Dearborn-Ohio
Baker, Milan	Culver	Marshall
Baker, Robert E. (H)	Orleans	Orange
Baker, Warren	Michigan City	LaPorte
Balch, James F.	Indianapolis	Marion
Baldridge, W. O.	Terre Haute	Vigo
Baldwin, J. H.	Jeffersonville	Clark
Balkema, Cath. M.	Lafayette	Tippecanoe
Ball, Clay A.	Muncie	Delaware-Blackford
Ball, Joseph E.	Indianapolis	Marion
Balla, Morris	South Bend	St. Joseph
Ballard, C. A.	Logansport	Cass
Ballard, John E.	Muncie	Delaware-Blackford
Ballard, Robert J.	Lebanon	Boone
Ballas, William A.	Evansville	Vanderburgh
Ballenger, W. E.	Richmond	Wayne-Union
Balsbaugh, George	N. Manchester	Wabash
Baltes, Joseph H.	Fort Wayne	Allen
Banister, R. F.	Indianapolis	Marion
Bankoff, Milton L.	Michigan City	LaPorte
Banks, H. M.	Indianapolis	Marion
Barclay, I. C.	Evansville	Vanderburgh
Bard, Frank B.	Crothersville	Jackson
Barnes, Helen B.	Greenwood	Johnson
Barnett, R. E.	Peru	Miami
Barnhart, Willard T.	Evansville	Vanderburgh
Barnum, Emerson	Shelbyville	Shelby
Barone, Carmelo V.	Mishawaka	St. Joseph
Barrett, D. C.	Indianapolis	Bartholomew-Brown
Barry, M. J.	Indianapolis	Marion
Barry, Maurice J., Jr.	Indianapolis	Marion
Bartholomew, A. C.	Fort Wayne	Allen
Bartholomew, Mary	Goshen	Elkhart
Bartle, J. Leo	Indianapolis	Marion
Bartley, Max D.	Indianapolis	Marion
Barton, Robert	Angola	Steuben
Barton, W. M.	Centerville	Wayne-Union
Bartsch, Harvey L.	South Bend	St. Joseph
Bash, Wallace E.	Fort Wayne	Allen
Baskett, R. J.	Jonesboro	Grant
Bassett, Clancy	Thorntown	Boone
Bassett, Margaret	Thorntown	Boone
Bassler, C. R.	Mishawaka	St. Joseph
Batman, Gordon W.	Indianapolis	Marion
Battersby, J. Stanley	Indianapolis	Marion
Batties, Paul A.	Indianapolis	Marion
Bauer, A. J.	Lafayette	Tippecanoe
Bauer, Thomas B.	Indianapolis	Marion
Baughn, William L.	Anderson	Madison
Baum, Harry	Indianapolis	Marion
Baumgartner, Jeraldine	Fort Wayne	Allen
Baxter, J. W., Jr.	New Albany	Floyd
Baxter, Neal	Bloomington	Owen-Monroe
Baxter, Samuel M.	New Albany	Floyd
Bayley, R. H.	Lafayette	Tippecanoe
Bayley, William E.	Lafayette	Tippecanoe
Baylor, Edward M.	Evansville	Vanderburgh
Beach, Robert R.	Indianapolis	Marion
Beam, Vernon B.	Lansing, Ill.	Lake
Beams, Ralph H.	Fort Wayne	Allen
Bean, Joseph S.	Indianapolis	Marion
Bear, L. H. (H)	Vevay	Switzerland
Beardsley, Frank A.	Frankfort	Clinton
Beardsley, John	Frankfort	Clinton
Beasley, T. J.	Indianapolis	Marion
Beaver, Ernest R.	Rensselaer	Jasper-Newton
Beaver, Howard W.	Indianapolis	Marion
Beaver, Norman	Berne	Adams
Bechtol, Lavon D.	Whiting	Lake
Bechtold, S. E.	South Bend	St. Joseph
Beck, Evart M.	Indianapolis	Marion
Beck, H. A.	Lebanon	Boone
Becker, Philip H.	Crown Point	Lake
Beckes, Ellsworth	Vincennes	Knox
Beckes, Norman E. (H)	Vincennes	Knox
Beckman, H. F.	Indianapolis	Marion
Beconovich, Robert	Hammond	Lake
Bedwell, Marion H.	Sullivan	Sullivan
Beeler, Bruce H.	Evansville	Vanderburgh
Beeler, J. Moss	Lafayette	Tippecanoe
Beeler, Raymond C.	Indianapolis	Marion
Beetem, L. F.	Madison	Jefferson
Beggs, L. F.	Columbus	Bartholomew-Brown
Behn, Walter M.	Gary	Lake
Beierlein, Karl	Fort Wayne	Allen
Beilke, Clifford A.	East Chicago	Lake
Benchik, Frank A.	East Chicago	Lake
Bender, Cecil K.	Goshen	Elkhart
Bender, Robert L.	Elkhart	Elkhart
Bendler, Carl H.	Gary	Lake
Benedek, Tibor	East Chicago	Lake
Benedict, Charles D.	LaGrange	LaGrange
Bennett, Abner P.	Evansville	Vanderburgh
Bennett, J. B.	Warren	Huntington
Bennett, Jene R.	South Bend	St. Joseph
Benninghoff, D. R.	Fort Wayne	Allen
Benoit, Merrill T.	Anderson	Madison
Benz, Jesse	Marengo	Crawford
Benz, O. F.	Wanatah	LaPorte
Bergan, Joseph A.	South Bend	Lake
Berger, Henry I.	Indianapolis	Marion
Berger, Morley	Beech Grove	Marion
Berghoff, Raymond	Fort Wayne	Allen
Berke, Robert	Mishawaka	St. Joseph
Berkebile, J. B.	Peru	Miami
Berman, Jacob K.	Indianapolis	Marion
Bernoske, D. G.	Michigan City	LaPorte
Beverland, M. E.	Indianapolis	Marion
Biasini, Benedict A.	South Bend	St. Joseph
Bibler, Henry E.	Muncie	Delaware-Blackford
Bibler, L. D.	Indianapolis	Marion

Name	City	County
Bickel, David A.	South Bend	St. Joseph
Bickel, J. E.	Fort Wayne	Allen
Bigelow, O. P.	Roanoke	Huntington
Billings, Elmer R.	Indianapolis	Marion
Billman, Gustus S.	Shelbyville	Shelby
Bills, L. F.	Culver	Lake
Bills, R. N.	Gary	Lake
Bird, Charles R.	Indianapolis	Marion
Birdzell, John P.	Crown Point	Lake
Birge, Jackson P.	Ypsilanti, Mich.	LaPorte
Birmingham, P. J.	South Bend	St. Joseph
Bishop, Charles A.	South Bend	St. Joseph
Bishop, Harry A.	Frankton	Madison
Bitler, C. C.	New Castle	Henry
Bixler, Louis C.	South Bend	St. Joseph
Bizer, Mier A.	Jeffersonville	Clark
Black, C. S.	Warren	Huntington
Black, Edgar K.	Wabash	Wabash
Black, Joe M.	Seymour	Jackson
Blackburn, Erwin	South Bend	St. Joseph
Blaize, J. L.	New Castle	Henry
Bland, H. E. (H)	Fairbanks	Sullivan
Blassaras, Chris	Anderson	Madison
Blatt, A. E.	Indianapolis	Marion
Blazey, A. G.	Washington	Daviess-Martin
Bledsoe, James G.	New Castle	Henry
Blemker, Russell M.	Greensburg	Decatur
Blessinger, Louis Henry	Corydon	Harrison
Blessinger, Paul J.	Jasper	Dubois
Blix, Fred M.	Ladoga	Montgomery
Bloemker, E. F.	Indianapolis	Marion
Bloom, Asa Ward	Marion	Grant
Bloom, George R.	Elkhart	Elkhart
Bloomer, J. R.	Rockville	Parke-Vermillion
Bloomer, R. S.	Rockville	Parke-Vermillion
Blosser, B. A.	Fremont	Steuben
Blosser, H. V. (H)	Fort Wayne	Allen
Blossom, Paul W.	Richmond	Wayne-Union
Blum, Leon L.	Terre Haute	Vigo
Boardman, Carl	Gary	Lake
Bock, Don G.	Indianapolis	Marion
Bodnar, Leslie M.	South Bend	St. Joseph
Bogardus, C. R.	Austin	Scott
Boggs, E. F.	Indianapolis	Marion
Bohner, C. B.	Indianapolis	Marion
Bolin, John T.	Cedar Lake	Lake
Bolin, Robert S.	Elkhart	Elkhart
Boling, Grover C., Jr.	Indianapolis	Marion
Bolka, B. J.	South Bend	St. Joseph
Bolman, Ralph M.	Fort Wayne	Allen
Bonaventura, A. P.	East Chicago	Lake
Bond, Charles S. (H)	Richmond	Wayne-Union
Bond, Walter	Clay City	Clay
Bonifield, H. F.	Warren	Huntington
Booher, Norman R.	Indianapolis	Marion
Booher, Olga	Indianapolis	Marion
Booth, Boynton H.	St. Louis, Mo.	Marion
Bopp, Henry W.	Terre Haute	Vigo
Bopp, James	Terre Haute	Vigo
Borders, Theo. R.	Fort Wayne	Allen
Boren, Paul	Poseyville	Posey
Boren, Samuel W. (H)	Poseyville	Posey
Borland, R. M.	Bloomington	Owen-Monroe
Borough, L. D	South Bend	St. Joseph
Boswell, Robert W.	Evansville	Vanderburgh
Bothwell, C. G.	Martinsville	Morgan
Botkin, Clyde G.	Muncie	Delaware-Blackford
Botkin, Thomas	Muncie	Delaware-Blackford
Bottorff, David C.	Charlestown	Clark
Boughman, Joseph D.	Kokomo	Howard
Bowdoin, G. E.	Elkhart	Elkhart
Bowen, Otis R.	Bremen	Marshall
Bower, Daniel L.	Indianapolis	Marion
Bowers, Copeland C.	Kokomo	Howard
Bowers, G. T.	Fort Wayne	Allen
Bowers, Garvey B.	Kokomo	Howard
Bowers, John A.	Kokomo	Howard
Bowers, J. W.	Fort Wayne	Allen
Bowles, J. H.	Muncie	Delaware-Blackford
Bowman, Charles M.	Albion	Noble
Bowman, George W.	Indianapolis	Marion
Boyd, C. L.	Vincennes	Knox
Boyd, Charles S.	East Chicago	Lake
Boyd, Clarence E.	West Baden	Orange
Boyd, Foster J., Jr.	Indianapolis	Marion
Boyd, Stella N.	Evansville	Vanderburgh
Boyer, E. B.	Indianapolis	Marion
Boyer, Floyd A.	Indianapolis	Marion
Boyer, Grace B.	Marion	Grant
Boys, F. F.	East Chicago	Lake
Bradfield, John C.	Logansport	Cass
Bradley, Stephen C.	Terre Haute	Vigo
Brady, Samuel	Gary	Lake
Brady, Thomas A.	Indianapolis	Marion
Brandman, Harry	Gary	Lake
Brauchla, C. H.	Anderson	Madison
Braun, Benjamin D.	Chicago, Ill.	Lake
Braunlin, Robert F.	Marion	Grant
Braunlin, W. H.	Marion	Grant
Brayton, John R.	Indianapolis	Marion
Brayton, Lee	Indianapolis	Marion
Brechtol, Harvey J.	Green Cave Springs, Fla.	St. Joseph
Brenner, I. E.	Winchester	Randolph
Brickley, H. D.	Bluffton	Wells
Brickley, Richard A.	Bluffton	Wells
Bridges, William L.	Markleville	Madison
Bridwell, Edgar	Bedford	Lawrence
Briggs, Carl F.	Sullivan	Sullivan
Briggs, J. H.	Churubusco	Whitley
Briscoe, C. E.	New Albany	Floyd
Britton, W. D.	Montezuma	Parke-Vermillion
Brock, Earl E.	Anderson	Madison
Brockmole, Arnold W.	Evansville	Vanderburgh
Brodie, Donald W.	Indianapolis	Marion
Bronson, Paul J.	Terre Haute	Vigo
Brookie, Roger Wm.	Flora	Carroll
Brooks, H. L.	Michigan City	LaPorte
Broomes, Edward L. C.	East Chicago	Lake
Broshears, Kenneth	Linton	Greene
Brosius, Robert H. W.	Ft. Wayne	Allen
Brother, Geo. M.	Indianapolis	Marion
Brown, A. E.	Indianapolis	Marion
Brown, D. B.	Gary	Lake
Brown, David E.	Indianapolis	Marion
Brown, Dewitt W.	Indianapolis	Marion
Brown, Edward A. (H)	Indianapolis	Marion
Brown, Frances T.	Indianapolis	Marion
Brown, Frederic W.	Ft. Wayne	Allen
Brown, George E.	Greenwood	Johnson
Brown, James A., Sr.	Evansville	Vanderburgh
Brown, James C.	Valparaiso	Porter
Brown, James M.	Indianapolis	Marion
Brown, J. S.	Carlisle	Sullivan
Brown, Karl T. (H)	Muncie	Delaware-Blackford
Brown, K. H.	New Albany	Floyd
Brown, Leland G.	Muncie	Delaware-Blackford
Brown, Leo R.	Gary	Lake
Brown, Marcel S.	Spencer	Owen-Monroe
Brown, R. E.	Cayuga	Parke-Vermillion
Brown, R. L.	Evansville	Vanderburgh

Name	City	County
Brown, Robert R.	Terre Haute	Vigo
Brown, Robert M.	Marion	Grant
Brown, Stanley L.	Hammond	Lake
Brown, Stewart D.	Albany	Delaware-Blackford
Brown, Thomas	Delphi	Carroll
Brown, Thomas M.	Muncie	Delaware-Blackford
Brown, Wendell E.	Indianapolis	Marion
Browne, William A.	Evansville	Vanderburgh
Browning, J. S.	Indianapolis	Marion
Browning, W. M.	Indianapolis	Marion
Brubaker, Harold S.	Huntington	Huntington
Brubaker, O. G.	N. Manchester	Wabash
Bruegge, T. J.	Kokomo	Howard
Bruetsch, Walter L.	Indianapolis	Marion
Bruggeman, H. O.	Ft. Wayne	Allen
Bruner, Ralph	Jeffersonville	Clark
Brunoehler, Carl J.	Indianapolis	Marion
Bryan, F. A.	Ft. Wayne	Allen
Bryan, Robert E.	Kendallville	Noble
Bryan, Robert J.	South Bend	St. Joseph
Bryan, S. L.	Evansville	Vanderburgh
Buchanan, W. D.	South Bend	St. Joseph
Buche, F. P.	Richmond	Wayne-Union
Buchholz, Ransom R.	Evansville	Vanderburgh
Buck, Charles E.	Indianapolis	Marion
Buckingham, Richard	Bloomington	Owen-Monroe
Buckles, David L.	Anderson	Madison
Buckley, E. P.	Jeffersonville	Clark
Buckner, Doster	Ft. Wayne	Allen
Buckner, George D.	Indianapolis	Marion
Buckner, Joy F.	Bluffton	Wells
Buechner, F. W.	South Bend	St. Joseph
Buhrmester, H. C.	Lafayette	Tippecanoe
Buikstra, C. R.	Evansville	Vanderburgh
Bullard, Mattie J.	Gary	Lake
Bulson, Eugene L.	Ft. Wayne	Allen
Bunde, Carl	Indianapolis	Marion
Bundy, C. Merle	Indianapolis	Washington
Bunker, L. Z.	N. Manchester	Wabash
Burcham, J. B.	Gary	Lake
Burdette, Harold F.	Indianapolis	Marion
Burge, A. D.	Marion	Grant
Burghard, D. Rolla	Indianapolis	Marion
Burk, James M.	Decatur	Adams
Burkhardt, B. A.	Tipton	Tipton
Burkle, J. C.	Lafayette	Tippecanoe
Burks, Jess E.	Crawfordsville	Montgomery
Burman, Richard G.	Jeffersonville	Clark
Burnett, Arthur B.	Indianapolis	Henry
Burney, Leroy E.	Indianapolis	Marion
Burnikel, Ray H.	Evansville	Vanderburgh
Burns, Kendall R.	Lafayette	Tippecanoe
Burns, Paul E.	Montpelier	Delaware-Blackford
Burress, B. O.	Washington	Daviess-Martin
Burris, F. L.	Michigan City	LaPorte
Burroughs, C. A.	Frankfort	Clinton
Burrous, E. Lee	Peru	Miami
Bush, Hargis R.	Cannelton	Perry
Bussard, C. F.	South Bend	St. Joseph
Bussard, Frank	South Bend	St. Joseph
Butler, John O.	Farmersburg	Sullivan
Butman, W. C.	Hebron	Porter
Butterfield, Robt. M.	Muncie	Delaware-Blackford
Buttz, Rose J.	Indianapolis	Marion
Byrn, H. W.	New Albany	Floyd
Byrne, Robert J.	Bicknell	Knox

C

Name	City	County
Cabell, A. L. (H)	Louisville, Ky.	Vigo
Cacia, John J.	Evansville	Vanderburgh
Cahal, Ernest	Indianapolis	Marion
Cahn, Hugo M.	Indianapolis	Marion
Cajacob, Melville E.	Terre Haute	Vigo
Caldwell, William C.	Evansville	Vanderburgh
Call, H. F.	Indianapolis	Marion
Callaghan, W. C.	Greensburg	Decatur
Callahan, R. H.	East Chicago	Lake
Calvert, R. R.	Lafayette	Tippecanoe
Calvin, Jessie C. (H)	Ft. Wayne	Allen
Cameron, D. F.	Ft. Wayne	Allen
Campagna, E. A.	East Chicago	Lake
Campbell, J. A.	Indianapolis	Marion
Campbell, P. A.	Richmond	Wayne-Union
Campbell, Sam W.	Carmel	Hamilton
Canaday, C. E.	New Castle	Henry
Canaday, J. W.	Indianapolis	Marion
Cannon, Daniel H.	New Albany	Floyd
Caplin, Irvin	Indianapolis	Marion
Caplin, S. S.	Indianapolis	Marion
Carbone, J. A.	Gary	Lake
Carey, W. W. (H)	Ft. Wayne	Allen
Carlberg, D. L.	Jeffersonville	Clark
Carleton, E. H.	East Chicago	Lake
Carlo, Ernest R.	Ft. Wayne	Allen
Carlo, J. F.	Hammond	Lake
Carlson, E. A. (H)	Peru	Miami
Carlson, Norman C.	Michigan City	Lake
Carlyle, Ivan E.	Michigantown	Clinton
Carmichael, C. S.	Seelyville	Vigo
Carmody, R. F.	Gary	Lake
Carneal, Thomas E.	Winamac	Pulaski
Carnes, Wm. M.	Earl Park	Benton
Carney, J. T.	Jeffersonville	Clark
Carney, John C.	Monticello	Tippecanoe
Carpenter, G. C.	Terre Haute	Vigo
Carpenter, J. L.	Alexandria	Madison
Carpenter, Thomas D.	Columbus	Bartholomew-Brown
Carpentier, Harry F.	Princeton	Gibson
Carrel, Francis E.	Frankfort	Clinton
Carroll, John C.	Decatur	Adams
Carson, Wayne	Indianapolis	Marion
Carter, F. R. Nicholas	South Bend	St. Joseph
Carter, Fred S.	LaPorte	LaPorte
Carter, James C.	Indianapolis	Marion
Carter, J. V.	Tipton	Tipton
Carter, Oren E.	Indianapolis	Marion
Cartwright, E. L.	Ft. Wayne	Allen
Cartwright, Jack D.	LaPorte	LaPorte
Casebeer, P. B.	Clinton	Parke-Vermillion
Caseley, Donald	Indianapolis	Marion
Casey, Stanley M.	Huntington	Huntington
Cassady, J. V.	South Bend	St. Joseph
Catlett, M. B.	Ft. Wayne	Allen
Caton, J. R.	South Bend	St. Joseph
Cavins, A. W.	Terre Haute	Vigo
Cavitt, Robert F.	Connersville	Fayette-Franklin
Cayley, Frank J.	Indianapolis	Marion
Caylor, Harold D.	Bluffton	Wells
Caylor, Truman E.	Bluffton	Wells
Challman, W. B.	Mt. Vernon	Posey
Chambers, A. R.	Ft. Wayne	Allen
Chambers, L. B.	Union City	Randolph
Chambers, William	South Bend	St. Joseph
Chandler, L. H.	Millersburg	Elkhart
Chattin, Herbert O.	Vincennes	Knox
Chattin, Robert E.	Loogootee	Daviess-Martin
Chattin, William R.	Indianapolis	Marion
Chattin, V. J.	Washington	Daviess-Martin
Chen, K. K.	Indianapolis	Marion
Chevigny, J. J.	Gary	Lake
Chidlaw, B. W.	Hammond	Lake
Childs, A. G. W. (H)	Madison	Jefferson
Childs, Wallace E.	Madison	Jefferson
Chimento, Dominic F.	Westerly, R. I.	Marion
Chittick, A. G.	Frankfort	Clinton

Name	City	County
Christophel, Verna	Mishawaka	St. Joseph
Chroniak, Walter	Indianapolis	Marion
Clancy, J. F.	Hammond	Lake
Clapp, Fred R.	South Bend	St. Joseph
Clark, C. P.	Indianapolis	Marion
Clark, Cyrus J.	Indianapolis	Marion
Clark, Fred O.	Syracuse	Elkhart
Clark, Ivan A.	Paoli	Orange
Clark, Joseph H.	Kendallville	Allen
Clark, Lawson J.	Indianapolis	Marion
Clark, M. E.	Cambridge City	Wayne-Union
Clark, Stanley A.	South Bend	St. Joseph
Clark, Wm. H.	South Bend	St. Joseph
Clark, W. R.	Ft. Wayne	Allen
Clarke, Elton R.	Kokomo	Howard
Clauser, E. H.	Muncie	Delaware-Blackford
Clements, A. F.	Evansville	Vanderburgh
Clevenger, J. H.	Muncie	Delaware-Blackford
Clevinger, Wm. G.	Kirklin	Clinton
Cline, Kenneth L.	Wyatt	St. Joseph
Close, W. D.	Indianapolis	Marion
Clouse, Paul A.	Evansville	Vanderburgh
Clunie, Wm. A.	Huntington	Huntington
Coats, Edwin A.	New Castle	Henry
Coble, F. H.	Richmond	Wayne-Union
Coble, R. R.	Indianapolis	Marion
Cockrum, Wm. M.	Evansville	Vanderburgh
Cody, B. L.	Evansville	Vanderburgh
Coffel, Melvin H.	Vincennes	Knox
Coffman, Delmar Lee	Clinton, Okla.	Vanderburgh
Cohen, Irving	Indianapolis	Marion
Cole, A. V.	East Chicago	Lake
Cole, Ira	Lafayette	Tippecanoe
Cole, Russel E.	Muncie	Delaware-Blackford
Coleman, Floyd B.	Waterloo	Dekalb
Coleman, H. G.	Odon	Daviess-Martin
Coleman, Joseph E.	Evansville	Vanderburgh
Colglazier, G. G.	Leipsic	Orange
Colip, George	South Bend	St. Joseph
Collett, Hugh S.	Phila., Pa.	Wells
Collins, Albert W. (H)	Anderson	Madison
Collins, Hubert L.	Indianapolis	Marion
Collins, J. N.	Indianapolis	Marion
Coloviras, Geo., Jr.	Lafayette	Tippecanoe
Combs, Charles N.	Terre Haute	Vigo
Combs, Herman	Evansville	Vanderburgh
Combs, John H.	Evansville	Vanderburgh
Combs, Nelson B.	Mulberry	Clinton
Combs, Pearl B.	Evansville	Vanderburgh
Combs, Stuart R.	Terre Haute	Vigo
Comer, Charles W.	Mooresville	Morgan
Comer, J. E.	Mooresville	Morgan
Comer, Kenneth E.	Mooresville	Morgan
Compton, C. B.	Frankfort	Clinton
Compton, George	Tipton	Tipton
Compton, Walter A.	Elkhart	Elkhart
Condit, David H.	South Bend	St. Joseph
Conger, Elizabeth (H)	Indianapolis	Marion
Congleton, G. C.	Terre Haute	Vigo
Conklin, James O.	Terre Haute	Vigo
Conklin, R. L.	Elkhart	Elkhart
Conley, John E.	Ft. Wayne	Allen
Conley, Joseph L.	Indianapolis	Marion
Conley, T. M.	Kokomo	Howard
Connell, P. S.	Plymouth	Marshall
Connell, Vactor O.	Bourbon	Marshall
Connelly, J. J.	Terre Haute	Vigo
Conner, T. E. (H)	Freetown	Jackson
Connerly, M. L.	Long Beach, Calif.	Marion
Connoy, Andrew F.	Westfield	Hamilton
Connoy, Leo	Westfield	Hamilton
Conrad, E. M. (H)	Anderson	Madison
Conrad, Henry W.	Milan	Ripley
Conway, Chester C.	Indianapolis	Marion
Conway, Glenn	Indianapolis	Marion
Cook, C. J. (H)	Indianapolis	Marion
Cook, Charles E.	North Manchester	Wabash
Cook, G. M.	Hammond	Lake
Cook, Gordon C.	South Bend	St. Joseph
Cook, Robert G.	Bluffton	Wells
Cooksey, T. L. (H)	Crawfordsville	Montgomery
Coomes, M. J. (H)	Shelbyville	Shelby
Cooney, Charles J.	Ft. Wayne	Allen
Coons, John D.	Lebanon	Boone
Coons, Ritchie	Lebanon	Boone
Cooper, H. L.	South Bend	St. Joseph
Cooper, Leo Kenneth	Gary	Lake
Cooper, Thomas L.	Logansport	Cass
Cope, Stanton E.	Huntington	Huntington
Copeland, G. W. (H)	Vevay	Switzerland
Copeland, S. J.	Indianapolis	Marion
Corcoran, Patrick J. V.	Evansville	Vanderburgh
Cormican, Herbert L.	Elkhart	Elkhart
Cornacchione, M.	Indianapolis	Marion
Cornell, Beaumont S.	Ft. Wayne	Adams
Corpe, Kenneth F.	Rushville	Rush
Cortese, James V.	Indianapolis	Marion
Cortese, Thomas A.	Indianapolis	Marion
Cotter, E. R.	East Chicago	Lake
Cotterman, Vernon L.	Gary	Lake
Cotton, S. M.	Goldsmith	Tipton
Coulson, S. B.	Waldron	Shelby
Coultas, P. J.	Tell City	Perry
Courtney, John W.	Indianapolis	Marion
Covalt, Wendell E.	Muncie	Delaware-Blackford
Covell, H. M.	Auburn	Dekalb
Cox, C. E.	Indianapolis	Marion
Cox, Harold	Indianapolis	Marion
Cox, Leon T.	Richmond	Wayne-Union
Cox, W. T.	Lafayette	Tippecanoe
Coy, Francis M.	Anderson	Madison
Coyner, A. B.	Lafayette	Tippecanoe
Craft, K. L.	Indianapolis	Marion
Craft, William F.	Linton	Greene
Craig, Alexander F.	Indianapolis	Henry
Craig, R. A.	Kokomo	Howard
Craig, Richard M.	Ft. Wayne	Allen
Craigmile, Thomas	Cowan	Delaware-Blackford
Crain, James Wm.	Williamsport	Fountain-Warren
Crampton, C. C. (H)	Delphi	Carroll
Crandall, Latham A.	Elkhart	Elkhart
Craven, Howard	Indianapolis	Marion
Crawford, James H.	Evansville	Vanderburgh
Crawford, T. R.	Terre Haute	Vigo
Creel, Donald	Angola	Steuben
Crevello, Albert J.	Evansville	Vanderburgh
Crimm, Paul D.	Evansville	Vanderburgh
Cring, George	Portland	Jay
Cripe, E. P.	Bremen	Marshall
Crockett, F. S.	Lafayette	Tippecanoe
Crossland, Stewart H.	Gary	Lake
Crowder, James H., Jr.	Sullivan	Sullivan
Crum, Marion M.	Angola	Steuben
Culbertson, C. S.	South Bend	St. Joseph
Culbertson, Clyde G.	Indianapolis	Marion
Cullen, P. K.	Indianapolis	Marion
Cullipher, J .E. (H)	Elwood	Madison
Cullnane, C. W.	Evansville	Vanderburgh
Culloden, William G.	Indianapolis	Marion
Culmer, W. N.	Bloomington	Owen-Monroe
Culp, John E.	Ft. Wayne	Allen
Cummings, D. J.	Brownstown	Jackson
Cunningham, J. M.	Indianapolis	Marion

Name	City	County
Cure, Elmer T.	Muncie	Delaware-Blackford
Currie, Robert W.	Lafayette	Tippecanoe
Curry, Claude A.	Terre Haute	Vigo
Curtner, M. L.	Vincennes	Knox
Custer, E. W.	South Bend	St. Joseph
Cuthbert, F. S.	Kokomo	Howard
Cuthbert, M. P.	Indianapolis	Marion

D

Name	City	County
Dahling, C. W.	New Haven	Allen
Dailey, J. E.	Terre Haute	Vigo
Dainko, A. J.	East Chicago	Lake
Dale, J. W.	Chesterton	Porter
Dale, Maxwell H.	Connersville	Fayette-Franklin
Daley, Edward H.	Oldenburg	Fayette-Franklin
Dalton, John E.	Indianapolis	Marion
Dalton, Naomi	Bloomington	Owen-Monroe
Dalton, William W.	Indianapolis	Marion
Dancer, C. R. (H)	Fort Wayne	Allen
Dando, George H. (H)	Hartford City	Delaware-Blackford
Daniel, J. C.	Indianapolis	Marion
Daniels, E. O.	Marion	Grant
Daniels, G. R.	Marion	Grant
Dannacher, William D.	Wabash	Wabash
Dare, Lee A.	Jeffersonville	Clark
Darling, Dorothy	Gary	Lake
Darroch, S. C.	Cayuga	Parke-Vermillion
Dassell, Paul Milton	Hammond	Lake
Datzman, Richard C.	Indianapolis	Marion
Daubenheyer, M. F.	Richmond	Jennings
Daugherty, F. N.	Crawfordsville	Montgomery
Daves, W. L.	Evansville	Vanderburgh
Davidoff, Manuel A.	Ossian	Wells
Davidson, N. Cort	Indianapolis	Marion
Davis, Alice H.	Hammond	Lake
Davis, Carl M.	Valparaiso	Porter
Davis, E. C.	Muncie	Delaware-Blackford
Davis, J. A.	Flat Rock	Shelby
Davis, John A.	Indianapolis	Marion
Davis, John C.	Logansport	Cass
Davis, Joseph B.	Marion	Grant
Davis, M. S.	Marion	Grant
Davis, Marvin R.	Columbus	Bartholomew-Brown
Davis, Neal	Gary	Lake
Davis, Parvin M.	New Albany	Floyd
Davis, Richard	Rochester, Minn.	Grant
Davis, Sam J.	Indianapolis	Marion
Davis, William	New Market	Montgomery
Day, Clark W.	Indianapolis	Marion
Day, George H.	New Albany	Floyd
Day, Theodore P.	Willoughey, O.	Vigo
Day, W. D. C.	Seymour	Jackson
Deal, Eleanor H.	Speedway City	Marion
Dean, Donald I.	Rushville	Rush
Dearmin, R. M.	Indianapolis	Marion
DeArmond, Murray	Indianapolis	Marion
Decker, H. B.	Terre Haute	Vigo
DeDario, L. M.	Elkhart	Elkhart
Deever, J. W.	Indianapolis	Marion
DeFries, John J.	New Paris	Elkhart
DeGrazia, E. J.	Valparaiso	Porter
DeLong, C. A. (H)	Gary	Lake
DeMotte, C. Bowen	Indianapolis	Marion
DeMotte, Russell A.	Bloomington	Owen-Monroe
DeNaut, J. F.	Knox	Starke
Denham, Robert H.	South Bend	St. Joseph
Denman, R. D.	Helmer	Steuben
Denny, Edgar C.	Richmond	Wayne-Union
Denny, Forrest L.	Indianapolis	Marion
Denny, Frank T.	Ladoga	Montgomery
Denny, J. W.	Indianapolis	Marion
Denny, Melvin H.	Rushville	Rush
Denton, Larkin D.	Greentown	Howard
Denzer, E. K.	Evansville	Vanderburgh
Denzer, Wm. Oliver	Evansville	Vanderburgh
Deppe, Charles F.	Franklin	Johnson
Derhammer, G. L.	Brookston	Tippecanoe
DeRyke, Gilbert R.	Bluffton	Wells
DesJean, Paul A.	Indianapolis	Marion
Dester, Herbert E.	Jagdeeshpur, India	Marion
DeTar, G. B. (H)	Winslow	Pike
Detrick, H. W.	Hammond	Lake
Dettloff, Frederick	Greencastle	Putnam
Deutsch, Wm.	Muncie	Delaware-Blackford
DeVoe, Kenneth	Woodburn	Allen
DeWees, Dwight L.	Indianapolis	Marion
Dewey, Fred N. (H)	Elkhart	Elkhart
Dewey, Geo. W. (H)	Lafayette	Tippecanoe
DeWitt, C. H. (H)	Valparaiso	Porter
Diamond, Leo	Marion	Grant
Dian, A. J.	Gary	Lake
Dian, Julia G. Kuzmitz	Gary	Lake
Dick, Fred, Jr.	Marion	Grant
Dick, Jack	New Albany	Floyd
Dickson, D. D.	Greensburg	Decatur
Dieckman, Herbert S.	Evansville	Vanderburgh
Diefendorf, Charles F.	Evansville	Vanderburgh
Dielman, F. C.	Fulton	Fulton
Dietl, E. L.	South Bend	St. Joseph
Dillman, Carl E.	Corydon	Harrison
Dilts, Robert	Indianapolis	Marion
Dingle, Paul	Richmond	Wayne-Union
Dininger, W. S.	Winchester	Randolph
Dintaman, Paul G.	Indianapolis	Marion
Dittmer, J. E.	Valparaiso	Porter
Dittmer, S. E.	Kouts	Porter
Dittmer, Thomas L.	Indianapolis	Porter
Ditton, I. W. (H)	Ft. Wayne	Allen
Dixon, Rex	Anderson	Madison
Dobbs, O. R.	Greencastle	Putnam
Dodd, Robert D.	South Bend	St. Joseph
Dodd, Roberts K.	Evansville	Vanderburgh
Dodds, James U.	Hartford City	Delaware-Blackford
Dodds, Wemple	Crawfordsville	Montgomery
Doenges, James L.	Anderson	Madison
Dolezall, Bernard J.	Indianapolis	Marion
Dollens, Claude	Oolitic	Lawrence
Dome, H. S. (H)	Tell City	Perry
Donahue, C. M.	Carmel	Hamilton
Donahue, G. R.	Lafayette	Tippecanoe
Donato, Albert M.	Indianapolis	Marion
Donchess, J. C.	Gary	Lake
Donham, William L.	Bicknell	Knox
Donnelly, Everett F.	South Bend	St. Joseph
Donnelly, Robert W.	Chicago, Ill.	Sullivan
Donner, Paul G.	Indianapolis	Marion
Donovan, S. J.	Michigan City	La Porte
Dorman, W. L.	Indianapolis	Marion
Dorrance, T. O.	Bluffton	Wells
Dorsey, Philip W.	Terre Haute	Vigo
Doty, J. R.	Gary	Lake
Douglas, G. R. (H)	Valparaiso	Porter
Douglas, William T.	Montpelier	Delaware-Blackford
Dowd, Joseph A.	Indianapolis	Marion
Dowell, E. H.	Rockville	Parke-Vermillion
Downard, Leland F.	Gaston	Delaware-Blackford

Name	City	County
Dragoo, Farrol	Middletown	Madison
Drake, John C.	Anderson	Madison
Drake, M. C.	Elwood	Madison
Draper, M. H.	Tampa, Fla.	Allen
Dreyer, Ralph W.	Knightstown	Henry
Dryden, Gale E.	Indianapolis	Marion
Dublin, Madeline P.	Francesville	Tippecanoe
Dubois, F. T. (H)	Liberty	Wayne-Union
Dubois, R. B.	Lafayette	Tippecanoe
Dudding, J. E.	Hope	Bartholomew-Brown
Duemling, Arnold H.	Ft. Wayne	Allen
Dugan, Thomas J.	Indianapolis	Marion
Dugan, Wm. M.	Indianapolis	Marion
Duggan, J. A.	South Bend	St. Joseph
Duke, B. E.	Decatur	Adams
Dukes, Betty	Dugger	Sullivan
Dukes, David A.	Tell City	Perry
Dukes, F. M.	Dugger	Sullivan
Dukes, Joe E.	Dugger	Sullivan
Dulin, Basil B.	Portland	Jay
Dunbar, Colin V.	Indianapolis	Marion
Duncan, J. S.	Gary	Lake
Duncan, Wm. F. (H)	Aurora	Dearborn-Ohio
Dunham, Wilbur F.	Kempton	Tipton
Dunlap, D. Logan	South Bend	St. Joseph
Dunn, F. W.	Muncie	Delaware-Blackford
Dunning, L. M.	Indianapolis	Marion
Dunstone, H. C.	Ft. Wayne	Allen
Dupes, L. E.	Hobart	Lake
Durkee, M. S.	Evansville	Vanderburgh
Dusard, Joseph C.	Bedford	Lawrence
Dutchess, C. T.	Galveston	Cass
Dutton, H. H.	Martinsville	Morgan
Dyar, E. W.	Indianapolis	Marion
Dycus, W. A.	Evansville	Vanderburgh
Dyer, G. W.	Terre Haute	Vigo
Dyer, Wallace K.	Evansville	Marion
Dyke, Richard W.	Indianapolis	Marion
Dykhuizen, T. A.	Frankfort	Clinton

E

Name	City	County
Eades, Ralph C.	Valparaiso	Porter
Earl, Max M.	Louisville, Ky.	Delaware-Blackford
Eastman, J. R., Jr.	Indianapolis	Marion
Eaton, E. R.	Indianapolis	Marion
Eaton, L. D.	Franklin	Johnson
Eaton, M. J.	Lafayette	Tippecanoe
Ebbinghouse, Tom	Richmond	Wayne-Union
Eberly, K. C.	Ft. Wayne	Allen
Ebert, J. Wayne	Indianapolis	Marion
Eberwein, J. H.	Indianapolis	Marion
Eby, Ida L.	Goshen	Elkhart
Eckert, Russell A.	Chicago, Ill.	Marion
Edlavitch, B. M.	Ft. Wayne	Allen
Edmonds, Kendrick	Bedford	Lawrence
Edmondson, R. E.	Terre Haute	Vigo
Edwards, Bernard	South Bend	St. Joseph
Edwards, Edward T., Jr.	Vincennes	Knox
Edwards, W. F.	New Albany	Floyd
Egan, Sherman	South Bend	St. Joseph
Egbert, Clarence	Muncie	Delaware-Blackford
Egbert, Herbert	Indianapolis	Marion
Egbert, Roy	Indianapolis	Marion
Eggers, E. L.	Hammond	Lake
Eggers, H. W.	Hammond	Lake
Egnatz, Nicholas	Hammond	Lake
Ehrich, W. S.	Evansville	Vanderburgh
Eicher, Palmer	Indianapolis	Marion
Eickenberry, H. W.	Indianapolis	Marion
Eisaman, Jack L.	Bluffton	Wells
Eisenberg, D. A.	Martinsville	Morgan
Eisenlohr, Eugen	Terre Haute	Vigo
Eisterhold, John A.	Evansville	Vanderburgh
Eldridge, Gail E.	Indianapolis	Marion
Elledge, Ray	Hammond	Lake
Ellerbrook, George E.	Vevay	Switzerland
Ellett, John, Jr.	Coatesville	Hendricks
Elliott, John C.	Guilford	Dearborn-Ohio
Elliott, L. A.	Elkhart	Elkhart
Elliott, R. A.	Gary	Lake
Elliott, R. H.	Connersville	Fayette-Franklin
Elliott, Thomas A.	New Orleans, La.	Elkhart
Ellis, Bert	Indianapolis	Marion
Ellis, Davis W., Jr.	Rushville	Rush
Ellis, George M.	Connersville	Fayette-Franklin
Ellis, Lyman H.	Lizton	Hendricks
Ellis, Seth	Anderson	Madison
Ellison, Alfred	South Bend	St. Joseph
Elshout, Clem H.	LaPorte	LaPorte
Elsner, L. W.	Seymour	Jackson
Elsten, A. W.	Anderson	Madison
Elston, L. W.	Ft. Wayne	Allen
Elston, Ralph W.	Ft. Wayne	Allen
Emenhiser, Donald C.	New Haven	Allen
Emenhiser, John L.	New Haven	Allen
Emery, Charles B.	Bedford	Lawrence
Emery, Charles H. (H)	Bedford	Lawrence
Emhardt, J. W. A.	Indianapolis	Marion
Emhardt, John T.	Indianapolis	Marion
Emme, R. W.	Harlan	Allen
Endicott, Wayne	Greenfield	Hancock
Engel, E. L.	Evansville	Vanderburgh
Engeler, J. E.	Lafayette	Tippecanoe
Engle, J. M.	Portland	Jay
Engle, Russell B.	Winchester	Randolph
Engleman, H. K.	Georgetown	Floyd
English, H. E.	Rensselaer	Jasper-Newton
English, H. M.	Gary	Lake
English, J. P.	South Bend	St. Joseph
Ensminger, L. A.	Indianapolis	Marion
Entner, Charles L.	Connersville	Fayette-Franklin
Enzor, O. K.	Indianapolis	Marion
Episcopo, A. R.	Salem	Washington
Erdel, Milton W.	Frankfort	Clinton
Erehart, A. D.	Anderson	Madison
Erehart, M. G.	Huntington	Huntington
Ericksen, Lester G.	South Bend	St. Joseph
Ericson, H. L.	Windfall	Tipton
Ernst, Clifford	Indianapolis	Marion
Ernst, H. C.	East Chicago	Lake
Eshleman, L. H. (H)	Marion	Grant
Estes, Ambrose C.	Bloomington	Owen-Monroe
Estlick, R. E.	Ft. Wayne	Allen
Ettl, Edward J.	Cromwell	Noble
Evans, Frederick H.	Indianapolis	Marion
Evans, Frederick J.	Clinton	Parke-Vermillion
Evans, Paul V.	Indianapolis	Marion
Evans, R. M.	Russiaville	Howard
Everly, Ralph	Indianapolis	Marion
Eviston, J. V.	Huntington	Huntington
Ewbank, J. Nelson	Richmond	Wayne-Union
Ewing, Nathaniel D.	Vincennes	Knox

F

Name	City	County
Fagaly, W. J.	Lawrenceburg	Dearborn-Ohio
Failey, Robert	Indianapolis	Marion
Fair, John R.	Augusta, Ga.	Noble

Name	City	County
Faith, I. L.	Newburgh	Warrick
Faltin, Ladislaus	South Bend	St. Joseph
Farabee, Charles R.	North Judson	Starke
Fargher, F. M.	Michigan City	La Porte
Fargher, R. A.	La Porte	La Porte
Farnsworth, S. A.	La Porte	La Porte
Farr, James	Martinsville	Morgan
Farrell, J. T.	Indianapolis	Marion
Farris, John J.	Washington	Daviess-Martin
Farver, M. A. (H)	Middlebury	Elkhart
Faul, Henry J.	Evansville	Vanderburgh
Faulkner, W. H.	Richmond	Wayne-Union
Faussett, C. Basil	Indianapolis	Marion
Feerer, Donald J.	Michigan City	La Porte
Feldman, Max	South Bend	St. Joseph
Fender, A. H.	Worthington	Greene
Ferguson, A. N.	Ft. Wayne	Allen
Ferguson, John T.	Hamlet	Starke
Ferguson, Wm. B.	W. Lafayette	Marion
Ferrara, Donald W.	Peru	Miami
Ferrara, Joseph F.	Franklin	Johnson
Ferrara, S. J.	Peru	Miami
Ferrell, Jesse E.	Fortville	Hancock
Ferrell, Mars B.	Fortville	Hancock
Ferry, John L.	Whiting	Lake
Ferry, P. W.	Kokomo	Howard
Fessler, G. S.	Rising Sun	Dearborn-Ohio
Fichman, A. M.	Fort Wayne	Allen
Fickas, Dallas	Evansville	Vanderburgh
Filipek, W. J.	South Bend	St. Joseph
Fipp, August L.	Rome City	Noble
Firestein, Ben	South Bend	St. Joseph
Firestein, Ray	South Bend	St. Joseph
Fischer, Burnell	Gary	Lake
Fischer, C. N.	La Porte	La Porte
Fischer, W. E.	Anderson	Madison
Fish, C. M.	South Bend	St. Joseph
Fish, Edson C.	South Bend	St. Joseph
Fisher, Gerald	Acton	Marion
Fisher, Henry	Marion	Grant
Fisher, John E.	Attica	Fountain-Warren
Fisher, John E.	New Castle	Henry
Fisher, Lawrence F.	South Bend	St. Joseph
Fisher, Walter S.	Columbus	Bartholomew-Brown
Fisher, William C.	Evansville	Vanderburgh
Fisk, Frank B.	Indianapolis	Marion
Fitch, Ray T.	Muncie	Delaware-Blackford
Fitzgerald, Brice E.	Logansport	Cass
Fitzgerald, William J.	Indianapolis	Marion
Fitzpatrick, James S.	Portland	Marion
Fitzsimmons, E. L.	Evansville	Vanderburgh
Flack, Russell A.	Lafayette	Tippecanoe
Flaherty, Walter T.	Michigan City	La Porte
Flanagan, E. P.	Walton	Cass
Flanigan, M. B.	Indianapolis	Marion
Flannigan, H. F.	LaGrange	LaGrange
Fleetwood, R. A.	Nappanee	Elkhart
Fleischer, J. C.	East Chicago	Lake
Fleming, C. F.	Elkhart	Elkhart
Fleming, Justus M.	Elkhart	Elkhart
Fletcher, Charles F.	Sunman	Dearborn-Ohio
Flick, John J.	Indianapolis	Marion
Flinn, John H.	Evansville	Vanderburgh
Flora, Joseph O.	Indianapolis	Marion
Fodor, Oscar	Seattle, Wash.	Shelby
Folck, J. K.	Princeton	Gibson
Folkening, N. C.	Indianapolis	Marion
Foltz, Lloyd E.	Brownsburg	Hendricks
Forbes, Violet Crabbe	Wolcott	Tippecanoe
Foreman, Harry L.	Indianapolis	Marion
Foreman, Walter A.	Brookville	Fayette-Franklin
Forry, Frank	Indianapolis	Marion
Forsee, Norman E.	Jeffersonville	Clark
Forster, N. K.	Pacific Palisades, Calif.	Lake
Forsyth, D. H.	Terre Haute	Vigo
Fosbrink, E. L.	Syracuse	Elkhart
Fosler, D. W.	Indianapolis	Marion
Foster, Ray T.	New Castle	Henry
Fountaine, Thomas J.	Bedford	Lawrence
Fouts, Paul J.	Indianapolis	Marion
Fowler, Richard R.	Bloomington	Owen-Monroe
Fox, C. Philip	Washington	Daviess-Martin
Fox, Maurice S.	Vincennes	Knox
Fox, R. H.	Bicknell	Knox
Foy, H. W.	Fort Wayne	Allen
Frank, J. R.	Valparaiso	Porter
Frank, L. L.	South Bend	St. Joseph
Franklin, William L.	Indianapolis	Marion
Frankowski, Clementine	Whiting	Lake
Frantz, Mount E.	Danville	Hendricks
Frasch, M. G.	Lafayette	Tippecanoe
Frash, De Von W.	South Bend	St. Joseph
Frazin, Bernard	Indianapolis	Marion
Freed, Carl A.	Attica	Fountain-Warren
Freed, James C.	Attica	Fountain-Warren
Freed, John E., Sr.	Terre Haute	Vigo
Freed, John E., Jr.	Terre Haute	Vigo
Freeman, F. M.	Goshen	Elkhart
French, Wm. G.	Evansville	Vanderburgh
Frey, William B.	South Bend	St. Joseph
Frey, Harley B.	Lafayette	Tippecanoe
Friedman, Isadore E.	Hammond	Lake
Friedman, Leo	Evansville	Vanderburgh
Friedman, Morris S.	South Bend	St. Joseph
Friedrich, Louis M. (H)	Hobart	Lake
Frith, Gladys D.	South Bend	St. Joseph
Frith, Louis G.	South Bend	St. Joseph
Fritsch, L. E.	Evansville	Vanderburgh
Frost, John W.	Indianapolis	Marion
Fry, Robert D.	Indianapolis	Marion
Frybarger, S. S.	Converse	Miami
Fullerton, R. L.	Indianapolis	Marion
Funk, John W.	Muncie	Delaware-Blackford
Funkhouser, A. G.	Indianapolis	Marion
Funkhouser, Elmer	Indianapolis	Marion
Fuqua, Harold B.	Terre Haute	Vigo
Furgason, Paul C.	Indianapolis	Marion
Furniss, S. A. (H)	Indianapolis	Marion
Fuson, W. J.	Greencastle	Putnam

G

Name	City	County
Gabe, Wm. E.	Indianapolis	Marion
Gable, H. B.	Monticello	White
Gaddy, Euclid T.	Indianapolis	Marion
Galante, Vincent J.	Gary	Lake
Galbreath, R. S.	Huntington	Huntington
Galbreath, J. P.	Burnettsville	White
Galliher, Marjorie J.	Muncie	Delaware-Blackford
Gallo, Wm. C.	Butler, Pa.	Marion
Gallup, Palmer R.	Indianapolis	Marion
Gambill, Wm. D.	Indianapolis	Marion
Gammieri, Robert L.	Indianapolis	Marion
Gannon, G. W.	Gary	Lake
Ganser, Richard A.	Mishawaka	St. Joseph
Gante, H. W.	Anderson	Madison
Ganz, Max	Marion	Grant
Garber, E. C.	Dunkirk	Jay
Garber, J. Neill	Indianapolis	Marion
Garber, Paul A.	South Whitley	Whitley
Garceau, George J.	Indianapolis	Marion

Name	City	County
Gardiner, Sprague H.	Indianapolis	Marion
Gardner, Buckman	Indianapolis	Marion
Gardner, M. D.	Michigan City	La Porte
Gardner, Russell A.	Michigan City	La Porte
Garfield, M. D.	Indianapolis	Marion
Garland, Edgar	Evansville	Vanderburgh
Garling, L. C.	Muncie	Delaware-Blackford
Garner, William	Indianapolis	Marion
Garner, W. Stanley	Indianapolis	Marion
Garner, Wm. H.	New Albany	Floyd
Garrett, John D. (H)	Indianapolis	Marion
Garrett, Robert A.	Indianapolis	Marion
Garrison, James L.	Cumberland	Marion
Garrison, Leon J.	Gas City	Grant
Garton, H. W.	Ft. Wayne	Allen
Gaskill, Herbert S.	Indianapolis	Marion
Gastineau, F. M.	Indianapolis	Marion
Gatch, W. D.	Indianapolis	Marion
Gates, George E.	South Bend	St. Joseph
Gaul, L. Edward	Evansville	Vanderburgh
Gaunt, Everett W.	Alexandria	Madison
Gehres, R. W.	Shelbyville	Shelby
Geick, Raymond	Fort Branch	Gibson
Geider, Roy A.	Indianapolis	Marion
Geiger, Dillon	Bloomington	Owen-Monroe
Geisinger, L. N.	Auburn	De Kalb
Geller, Samuel	Owensville	Gibson
Gentile, John P.	New Albany	Floyd
George, Charles L.	Indianapolis	Marion
Gerding, William J.	Fort Wayne	Allen
Gerrish, D. A.	Terre Haute	Vigo
Gerrish, W. D.	Clinton	Parke-Vermillion
Gery, Richard E.	Lafayette	Tippecanoe
Gessler, W. F.	Fort Wayne	Allen
Gevirtz, M. B.	Hammond	Lake
Gibbs, Charles	Greenfield	Hancock
Gibbs, Joseph W.	Danville	Hendricks
Gibson, Greta	Indianapolis	Marion
Gick, Herman	Indianapolis	Marion
Gifford, F. E.	Indianapolis	Marion
Gilbert, Ivan	Terre Haute	Vigo
Gill, Bernard P.	Evansville	Vanderburgh
Gill, Dee Dar	Greenfield	Hancock
Gill, Thomas A.	Muncie	Delaware-Blackford
Gillespie, Chas. E.	Seymour	Jackson
Gillespie, Chas. F.	Indianapolis	Marion
Gillespie, G. R.	Brownstown	Jackson
Gillespie, J. E.	Indianapolis	Marion
Gillespie, J. F. (H)	Greencastle	Putnam
Gilliatt, J. P.	Salem	Washington
Gillum, John R.	Terre Haute	Vigo
Gilman, M. M.	South Bend	St. Joseph
Gilmore, R. A.	Michigan City	La Porte
Gingerick, Chas. M.	Liberty Center	Wells
Ginsberg, Stewart	Marion	Grant
Giordano, A. S.	South Bend	St. Joseph
Girod, Arthur H.	Decatur	Adams
Gish, Howard M.	Indianapolis	Marion
Gitlin, Max M.	Bluffton	Wells
Gitlin, Wm. A.	Bluffton	Wells
Givner, David	Indianapolis	Marion
Glackman, J. C., Sr.	Rochester	Fulton
Gladstone, N. H.	Fort Wayne	Allen
Glaser, Robert E.	Brookville	Fayette-Franklin
Glass, R. L.	Indianapolis	Marion
Glendening, J. L.	Indianapolis	Marion
Glenn, Fred C.	Tell City	Perry
Glenn, L. F.	Ramsey	Harrison
Glock, H. E.	Fort Wayne	Allen
Glock, M. E.	Ft. Wayne	Allen
Glock, Wayne R.	Ft. Wayne	Allen
Glosson, Jack R.	Clay City	Clay
Gobbel, N. E.	English	Crawford
Goethals, Charles J.	Mishawaka	St. Joseph
Goldberg, Harold B.	Gary	Lake
Goldstone, Adolph	Gary	Lake
Goldstone, Joseph	Gary	Lake
Goldstone, S. R.	Gary	Lake
Good, R. P.	Kokomo	Howard
Goodman, Eli	Charlestown	Clark
Goodman, H. T.	Terre Haute	Vigo
Goodwin, C. B. (H)	Kendallville	Noble
Goraczewski, Thaddeus	South Bend	St. Joseph
Gordin, Stanley	Connersville	Fayette-Franklin
Gordin, Stanton E. (H)	Connersville	Fayette-Franklin
Gordon, Joseph L.	Wheeler	Porter
Gordon, J. M.	South Bend	St. Joseph
Gorton, Mary L.	Gary	Lake
Gosman, James H.	Indianapolis	Marion
Gossard, Meredith B.	Tipton	Tipton
Gossom, Donn R.	Terre Haute	Vigo
Gotlib, Milton H.	Indianapolis	Marion
Gould, L. K.	Ft. Wayne	Allen
Govorchin, Alexander	East Chicago	Lake
Graessle, Harold P.	Seymour	Jackson
Graf, John P.	Indianapolis	Marion
Graf, Jerome A.	Bloomfield	Greene
Graham, George M.	Ft. Wayne	Allen
Graham, Thomas	Lafayette	Tippecanoe
Grant, Benjamin F.	Gary	Lake
Graves, J. W.	Indianapolis	Marion
Graves, Noel S.	Indianapolis	Marion
Graves, Orville M.	Princeton	Gibson
Gray, Clyde C.	Cloverdale	Putnam
Gray, D. E.	Crown Point	Lake
Gray, Leon	Martinsville	Morgan
Gray, Paul M.	Huntington	Huntington
Grayston, F. W. (H)	Huntington	Huntington
Grayston, Wallace S.	Huntington	Huntington
Green, Carl L.	Vincennes	Knox
Green, F. H., Jr.	Rushville	Rush
Green, George F.	South Bend	St. Joseph
Green, John H.	North Vernon	Jennings
Green, Norval E.	South Bend	St. Joseph
Green, Oscar	Indianapolis	Marion
Green, Paul A.	Indianapolis	Marion
Green, S. I.	St. Bernice	Parke-Vermillion
Green, Wm. L.	Pekin	Washington
Greene, Claude D.	Spencer	Owen-Monroe
Greene, Wm. R.	Henryville	Clark
Gregg, Albert F.	Connersville	Fayette-Franklin
Gregg, Edwin E.	Thorntown	Boone
Greiber, Marvin F.	Muncie	Delaware-Blackford
Greip, Arthur H.	Evansville	Vanderburgh
Greist, John	Indianapolis	Marion
Griffin, J. P.	Chesterton	Porter
Griffis, V. C.	Richmond	Wayne-Union
Griffith, Harold	Vevay	Switzerland
Griffith, James W.	Sheridan	Hamilton
Griffith, R. E.	Indianapolis	Marion
Grillo, Donald	South Bend	St. Joseph
Grimes, J. H.	Martinsville	Hendricks
Grisell, Ted L.	Indianapolis	Marion
Griswold, W. R.	Mare Island, Calif.	Marion
Gros, Hubert	Delphi	Carroll
Grossman, W. L.	North Vernon	Jennings
Grosso, W. G.	East Chicago	Lake
Grove, Robert H.	Rossville	Clinton
Gullett, Charles C.	Union City	Randolph
Gunderson, Shaun D.	Indianapolis	Marion
Gustafson, G. W.	Indianapolis	Marion
Gustafson, Milton	Muncie	Delaware-Blackford
Gustaitis, John W.	East Chicago	Lake
Gutelius, C. B.	Indianapolis	Marion

Name	City	County
Guthrie, F. C.	Anderson	Madison
Guthrie, James R.	Indianapolis	Marion
Gutierrez, F. A.	Gary	Lake
Gutstein, Richard R.	Kendallville	Noble
Gwaltney, L. F.	Roachdale	Putnam
Gwin, Merle D.	Miami Beach, Fla.	Jasper-Newton
H		
Habegger, Myron L.	Berne	Adams
Habich, Carl	Indianapolis	Marion
Hack, E. C.	Hammond	Lake
Hade, Frederick L.	Bridgeport	Marion
Hadley, David	Indianapolis	Marion
Hadley, Harvey	Richmond	Wayne-Union
Hadley, Murray N. (H)	Indianapolis	Marion
Haffner, H. G.	Ft. Wayne	Allen
Haggard, E. B.	Indianapolis	Marion
Hagie, F. E.	Richmond	Wayne-Union
Hahn, E. V.	Indianapolis	Marion
Haley, Paul E.	South Bend	St. Joseph
Halfast, Richard W.	Kokomo	Howard
Hall, Bernard R.	Logansport	Cass
Hall, E. H.	Dunkirk	Delaware-Blackford
Hall, Frank M.	Indianapolis	Marion
Hall, Jack R.	Indianapolis	Marion
Hall, Orville A.	Muncie	Delaware-Blackford
Hall, Thomas C.	Chesterton	Porter
Hallam, F. T.	Indianapolis	Marion
Halleck, H. J.	Winamac	Pulaski
Haller, Thomas C.	Crawfordsville	Montgomery
Hamer, Homer G.	Indianapolis	Marion
Hamilton, Antha A.	Shelburn	Sullivan
Hamilton, Charles O.	South Bend	St. Joseph
Hamilton, Emory D.	Ft. Wayne	Allen
Hamilton, J. R.	Mitchell	Lawrence
Hamilton, M. Luther	Newberry	Greene
Hamilton, Orville G.	Bluffton	Wells
Hamilton, Robert C.	East Chicago	Lake
Hammel, Howard T.	Bedford	Lawrence
Hammer, Jay Wm.	Middletown	Delaware-Blackford
Hammersley, Geo. K.	Frankfort	Clinton
Hammond, Keith	Paoli	Orange
Hammond, R. Case	Evansville	Vanderburgh
Hammond, Stanley M.	Portland	Jay
Hampshire, Don R.	Indianapolis	Marion
Hancock, John G.	Indianapolis	Marion
Hanley, Edward J.	Indianapolis	Marion
Hanna, Duke	Red Key	Jay
Hanna, T. A.	Indianapolis	Marion
Hannah, Jack W.	Wakarusa	Elkhart
Hansell, R. M.	Indianapolis	Marion
Hansen, A. H.	Hammond	Lake
Hanson, Martin F.	Elwood	Madison
Harcourt, A. K.	Indianapolis	Marion
Harden, Murray E.	W. Lafayette	Tippecanoe
Hardin, W. E.	Ossian	Wells
Harding, M. Richard	Indianapolis	Marion
Harding, Myron S.	Indianapolis	Marion
Hardy, Chas. F. (H)	Kendallville	Noble
Hardy, John J.	North Liberty	St. Joseph
Hare, Daniel M.	Evansville	Vanderburgh
Hare, E. H.	Indianapolis	Marion
Hare, John H.	Evansville	Vanderburgh
Hare, Laura	Indianapolis	Marion
Harger, Robert W.	Indianapolis	Marion
Harkcom, H. E.	St. Paul	Decatur
Harkness, R. G.	Terre Haute	Vigo
Harlan, William	Ligonier	Noble
Harless, Clarence M.	Chesterton	Porter
Harmon, C. J.	Richmond	Wayne-Union
Harmon, Gladys H.	Richmond	Wayne-Union
Harmon, Vachelle E.	South Bend	St. Joseph
Harmon, Wayne	Lynn	Randolph
Harold, A. H.	Indianapolis	Marion
Harold, N. E. (H)	Indianapolis	Marion
Harris, Carl B.	Indianapolis	Marion
Harris, Donald M.	Gary	Lake
Harris, Paul N.	Indianapolis	Marion
Harris, R. F.	Noblesville	Hamilton
Harris, Wm. Lee	Evansville	Vanderburgh
Harrison, Wm. H. (H)	Kokomo	Howard
Harshman, L. P.	Ft. Wayne	Allen
Harshman, Martin L.	Lafayette	Tippecanoe
Harstad, Casper	Rockville	Parke-Vermillion
Hart, L. Paul	University City, Mo.	Vanderburgh
Hart, Robert B.	Columbus	Bartholomew-Brown
Hart, Wm. D.	Anderson	Madison
Harter, Eli Blair	Lafayette	Tippecanoe
Hartley, C. A., Jr.	Evansville	Vanderburgh
Hartman, John	Angola	Steuben
Hartz, F. Minton	Evansville	Vanderburgh
Harvey, Harry C.	Ft. Wayne	Allen
Harvey, R. J.	Zionsville	Boone
Harvey, Verne K.	Alexandria, Va.	Marion
Hasewinkle, A. M.	Ft. Wayne	Allen
Hasewinkel, Carroll	Indianapolis	Marion
Hash, John S.	Noblesville	Hamilton
Haslem, Ezra R.	Terre Haute	Vigo
Haslem, John R.	Terre Haute	Vigo
Hasler, Norman B.	Indianapolis	Marion
Haslinger, C. J.	Indianapolis	Marion
Hastings, Warren C.	Ft. Wayne	Allen
Hatfield, B. F.	Indianapolis	Marion
Hatfield, Jack J.	Indianapolis	Marion
Hatfield, N. W.	Indianapolis	Marion
Hathaway, Clayton B.	Butler	DeKalb
Hattendorf, A. P.	Ft. Wayne	Allen
Haugseth, Ellsworth K.	South Bend	St. Joseph
Hauss, Augustus P.	New Albany	Floyd
Havens, Oscar	Cicero	Hamilton
Havens, R. E.	Ft. Wayne	Allen
Havice, Jay F.	Lake Lure, N. C.	Allen
Hawes, J. K. (H)	Columbus	Bartholomew-Brown
Hawes, M. E.	Columbus	Bartholomew-Brown
Hawk, James H.	Indianapolis	Marion
Hayes, Jess D.	East Chicago	Lake
Hayes, T. R.	Muncie	Delaware-Blackford
Haymond, George N.	Warsaw	Kosciusko
Haymond, Joseph L.	Indianapolis	Marion
Hays, Everett L.	Indianapolis	Marion
Hays, George R.	Richmond	Wayne-Union
Hazinski, R. T.	Griffith	Lake
Headley, L. M.	Lebanon	Boone
Heard, Albert	Evansville	Vanderburgh
Heath, Rebecca Hall	Butlerville	Jennings
Heberer, J. M.	Evansville	Vanderburgh
Heck, Rolfe A.	College Corner, Ohio	Wayne-Union
Hedde, E. L.	Logansport	Cass
Hedgcock, R. A.	Frankfort	Clinton
Hedrick, Philip W.	Indianapolis	Marion
Hefti, Karl R.	Evansville	Vanderburgh
Heilman, W. C.	New Castle	Henry
Heinrich, Weston A.	Evansville	Vanderburgh
Heinz, Dorothy C. V.	Indianapolis	Marion
Held, George A.	Jasper	Dubois
Heller, N. L.	Dunkirk	Jay
Heller, Oscar (H)	Greenfield	Hancock
Helmen, H. W.	South Bend	St. Joseph
Helper, Morton	Evansville	Vanderburgh

Name	City	County
Henderson, Arvin	Ridgeville	Randolph
Henderson, Francis G.	Indianapolis	Indianapolis
Henderson, N. C.	Michigan City	LaPorte
Henderson, R. A.	Muncie	Delaware-Blackford
Hendricks, John D.	Indianapolis	Marion
Hendricks, John W.	Indianapolis	Marion
Hennessee, Philip C.	Indianapolis	Jay
Henning, Carl	Hanover	Jefferson
Henry, Alvin L.	Columbus	Bartholomew-Brown
Henry, Howard J.	Knox	Starke
Henry, Russell S.	Indianapolis	Marion
Hensler, B. M.	Anderson	Madison
Hepburn, C. K.	Indianapolis	Marion
Hepner, H. S.	Bloomington	Owen-Monroe
Herd, Cloyn R.	Peru	Miami
Herendeen, E. V.	Rochester	Fulton
Heritier, C. Jules	Columbia City	Whitley
Herr, John W.	Mt. Vernon	Posey
Herrick, C. L.	Akron	Fulton
Herring, G. N.	Pierceton	Kosciusko
Herrmann, Gordon T.	Indianapolis	Marion
Herrold, G. W.	Lafayette	Tippecanoe
Hershey, E. A.	Churubusco	Whitley
Herzer, C. C.	Evansville	Vanderburgh
Hess, Paul P.	New Albany	Floyd
Hetherington, A. M.	Indianapolis	Marion
Hetherington, John A.	Indianapolis	Marion
Hetman, Mitchell J.	Westville	LaPorte
Heubi, John E.	Indianapolis	Marion
Hewitt, M. I.	South Bend	St. Joseph
Hiatt, R. L.	Ft. Wayne	Wayne-Union
Hibner, Nolan A.	Monticello	White
Hickman, A. Lee	Hammond	Lake
Hickman, W. R.	Logansport	Cass
Hickman, Walter	Indianapolis	Marion
Hicks, Joseph (H)	Arcadia	Hamilton
Hiestand, H. J.	Pennville	Jay
Higgins, James L.	Petersburg	Pike
Higgins, O. C.	Lebanon	Boone
High, Ralph L.	Muncie	Delaware-Blackford
Hilbert, John W.	South Bend	St. Joseph
Hildebrand, W. O.	Topeka	LaGrange
Hill, Edward C.	Hamilton, Cal.	Marion
Hill, H. D.	Richmond	Wayne-Union
Hill, H. E.	Muncie	Delaware-Blackford
Hill, Kenneth G.	New Castle	Henry
Hill, Paul G.	Cambridge City	Wayne-Union
Hill, Robert	Muncie	Delaware-Blackford
Hill, T. N.	Scottsburg	Scott
Hilldrup, Don G	Fort Sill, Okla.	Marion
Hillenbrand, Charles	Michigan City	LaPorte
Hillis, L. J.	Logansport	Cass
Hillman, Marion W.	South Bend	St. Joseph
Hillman, W. H. (H)	South Bend	St. Joseph
Himebaugh, Gilbert	Veedersburg	Fountain-Warren
Himebaugh, J. R. S.	Indianapolis	Marion
Himler, James M.	Indianapolis	Marion
Hinchman, C. P.	Geneva	Adams
Hinchman, Jean F.	Parker	Delaware-Blackford
Hine, U. B.	Indianapolis	Marion
Hines, A. V.	Auburn	DeKalb
Hines, Don C.	Indianapolis	Marion
Hinkson, George D.	Gary	Lake
Hippensteel, R. R.	Indianapolis	Marion
Hisrich, L. W.	Batesville	Ripley
Hobbs, Arthur	Evansville	Vanderburgh
Hochhalter, Marion	Logansport	Cass
Hodges, Fletcher	Indianapolis	Marion
Hodges, Wm. A.	Oaktown	Knox
Hodgin, Phillip	Orleans	Orange
Hodurski, Zigfield	Gary	Lake
Hoeger, H. R.	Brookville	Fayette-Franklin
Hofferkamp, A. G.	Louisville, Ky.	Floyd
Hoffman, A. F.	Ft. Wayne	Allen
Hoffman, Curtis R.	Richmond	Wayne-Union
Hoffman, Doris	Vincennes	Knox
Hoffman, Herman	Hartford City	Delaware-Blackford
Hoffman, R. V.	South Bend	St. Joseph
Hoffman, Robert V., Jr.	South Bend	St. Joseph
Hoffmann, S. P., Sr.	Ft. Wayne	Allen
Hofmann, Andrew	Hammond	Lake
Hofmann, J. Wm.	Indianapolis	Marion
Hogle, Frank D.	Logansport	Cass
Holdeman, Lillian	South Bend	St. Joseph
Holdeman, R. W.	South Bend	St. Joseph
Holladay, L. J.	Lafayette	Tippecanoe
Holland, Chas. E.	Bloomington	Owen-Monroe
Holland, D. J.	Bloomington	Owen-Monroe
Holland, Philip	Bloomington	Owen-Monroe
Holliday, L. D.	Fairmount	Grant
Hollingsworth, A. A.	Indianapolis	Marion
Hollingsworth, Marshall P. (H)	Princeton	Gibson
Hollis, Walter H.	Ft. Branch	Marion
Holloway, W. A. (H)	Logansport	Cass
Holman, J. E., Sr.	Indianapolis	Marion
Holman, J. E., Jr.	Indianapolis	Marion
Holmes, Claude D.	Indianapolis	Marion
Holmes, Claude D., Sr.	Frankfort	Clinton
Holmes, G. W.	Chicago, Ill.	Lake
Holmes, W. W.	Logansport	Cass
Holsinger, R. E.	Ft. Wayne	Allen
Holtzendorf, C. E. (H)	St. Petersb'g, Fla.	Marshall
Holtzman, Paul W.	Toledo, O.	Wells
Honan, Paul R.	Lebanon	Boone
Hood, Ainslee A.	Indianapolis	Marion
Hooke, Sam W.	Noblesville	Hamilton
Hoopes, Jane	Evansville	Vanderburgh
Hoover, D. A.	Terre Haute	Vigo
Hoover, J. Guy	Boonville	Warrick
Hoover, J. J.	Terre Haute	Vigo
Hoover, Peter B.	Boonville	Warrick
Hopkins, J. R.	Hammond	Lake
Hopkins, Lester H.	Versailles	Ripley
Hoppenrath, Wm. (H)	Elwood	Madison
Horst, William N.	Crown Point	Lake
Horswell, R. G.	Bristol	Elkhart
Horwitz, Thomas	Indianapolis	Marion
Horton, George R.	Ft. Wayne	Allen
Hostetler, Carl M.	Goshen	Elkhart
Hostetter, Irwin S.	Muncie	Delaware-Blackford
Houser, D. Stanley	Lakeville	St. Joseph
Houser, Wayne W.	Monon	Tippecanoe
Houseworth, John H.	Indianapolis	Marion
Houston, Fred D.	Lawrenceburg	Dearborn-Ohio
How, John T. (H)	Lakeville	St. Joseph
How, Louis E.	South Bend	St. Joseph
Howard, W. H.	Hammond	Lake
Howe, Fordyce L.	Ft. Wayne	Allen
Howell, Joseph D.	Indianapolis	Marion
Howell, R. D.	Indianapolis	Marion
Hoyt, Lester H.	Indianapolis	Marion
Huber, Carl P.	Indianapolis	Marion
Huckereide, Mark H.	Indianapolis	Marion
Huckleberry, Carl D.	Danville	Hendricks
Huckleberry, Irvin	Salem	Washington

Name	City	County
Hudson, Foster J.	Indianapolis	Marion
Huff, A. D.	Marion	Grant
Huffman, A. D.	South Bend	St. Joseph
Huffman, V. P.	South Whitley	Whitley
Hufnagel, C. A.	Brookline, Mass.	Wayne-Union
Hughes, L. M.	Paragon	Morgan
Hughes, Richard R.	Lafayette	Marion
Hughes, W. F. (H)	Indianapolis	Marion
Huggins, Victor S.	Evansville	Vanderburgh
Hull, A. W.	Elkhart	Elkhart
Hull, James E.	Wolcott	Tippecanoe
Hull, Ronald H.	Indianapolis	Marion
Hummel, R. M.	Marion	Grant
Hummons, Henry L.	Indianapolis	Marion
Humphrey, Paul E.	Terre Haute	Vigo
Humphreys, Joe E.	Vincennes	Knox
Hunn, M. F.	Elkhart	Elkhart
Hunsberger, W. G.	Lafayette	Tippecanoe
Hunt, Edgar J.	Terre Haute	Vigo
Hunt, Gayle J.	Richmond	Wayne-Union
Hunter, F. P.	Lafayette	Tippecanoe
Hunter, Lowell G.	Milan	Ripley
Huoni, J. S.	Jeffersonville	Clark
Hupe, Charles (H)	Lafayette	Tippecanoe
Hurley, Anson	Muncie	Delaware-Blackford
Hurley, John R.	Daleville	Delaware-Blackford
Hurt, L. B.	Indianapolis	Marion
Huse, William M.	Indianapolis	Marion
Husted, Robert	Hammond	Lake
Hutcheson, W. R. (H)	Greencastle	Putnam
Hutchison, Donald R.	Fountain City	Wayne-Union
Hutto, W. H.	Kokomo	Howard
Hyatt, Gilbert T.	Evansville	Vanderburgh
Hyde, Carroll	South Bend	St. Joseph

I

Name	City	County
Iddings, J. W.	Crown Point	Lake
Ikins, R. G.	Lafayette	Tippecanoe
Imhof, Joseph D.	Muncie	Delaware-Blackford
Ingwell, Guy B.	Knox	Starke
Inlow, Herbert	Shelbyville	Shelby
Inlow, W. D.	Shelbyville	Shelby
Irey, P. R.	Plymouth	Marshall
Irwin, Glenn W., Jr.	Indianapolis	Marion
Irwin, Seth	Summitville	Madison
Iske, Paul G.	Indianapolis	Marion
Isler, N. C.	Jeffersonville	Clark
Iterman, G. E.	New Castle	Henry
Ives, R. J.	Francesville	Pulaski

J

Name	City	County
Jackson, Dean B.	Hartford City	Delaware-Blackford
Jackson, F. E.	Indianapolis	Marion
Jackson, James W.	Indianapolis	Marion
Jackson, John F.	Indianapolis	Wells
Jackson, J. K.	Aurora	Dearborn-Ohio
Jackson, Jesse L.	Indianapolis	Marion
Jacobs, H. A.	Indianapolis	Marion
Jaeger, A. S.	Indianapolis	Marion
James, N. A.	Tell City	Perry
James, Thomas, Jr.	Huntington	Huntington
Jaquith, O. S. (H)	Indianapolis	Marion
Jarrett, Paul E.	Anderson	Madison
Jay, Arthur N.	Indianapolis	Marion
Jay, Robert	Honolulu, Hawaii	Marion
Jeffries, K. I.	Indianapolis	Marion
Jenkins, Robert E.	Indianapolis	Marion
Jennings, Frank	Indianapolis	Marion
Jewell, Earl B.	Logansport	Cass
Jewell, George M.	Kokomo	Howard
Jewett, Joe H.	Indianapolis	Marion
Jinks, C. H.	Indianapolis	Marion
Jinnings, Loren E.	Garrett	DeKalb
Jobes, James E.	Indianapolis	Marion
Jobes, N. E. (H)	Indianapolis	Marion
Joest, Charles O.	Mishawaka	St. Joseph
Johns, D. R.	East Chicago	Lake
Johns, Elmer	Zionsville	Boone
Johns, N. C.	South Bend	St. Joseph
Johnson, C. E.	Rensselaer	Jasper-Newton
Johnson, Earl E.	Covington	Fountain-Warren
Johnson, F. D.	Waynetown	Montgomery
Johnson, G. C. (H)	Evansville	Vanderburgh
Johnson, George M.	Richmond	Wayne-Union
Johnson, Herbert S.	Lafayette	Tippecanoe
Johnson, James B.	Greencastle	Putnam
Johnson, J. J. (H)	Milltown	Crawford
Johnson, Lonnie B.	Gary	Lake
Johnson, Lowell R.	Lafayette	Tippecanoe
Johnson, M. H. C.	Vincennes	Knox
Johnson, Owen	Peru	Miami
Johnson, Paul Dewey	Terre Haute	Vigo
Johnson, Paul S.	Richmond	Wayne-Union
Johnson, R. B.	Rushville	Rush
Johnson, S. L.	Evansville	Vanderburgh
Johnson, Thomas W.	Indianapolis	Marion
Johnson, W. A.	Perrysville	Parke-Vermillion
Johnson, Wm. F.	Indianapolis	Marion
Johnston, D. D.	Indianapolis	Allen
Johnston, Robert L.	Bluffton	Wells
Johnston, R. G.	Huntington	Huntington
Jolly, Lewis E.	Madison	Jefferson
Jolly, W. P.	Richland	Spencer
Jones, Albert T.	Anderson	Madison
Jones, Charles A.	Franklin	Johnson
Jones, Clifford M.	Whiting	Lake
Jones, D. D. (H)	Berne	Adams
Jones, David	Lafayette	Tippecanoe
Jones, David E.	Indianapolis	Marion
Jones, E. S.	Hammond	Lake
Jones, Francis P.	Indianapolis	Marion
Jones, George	Wanamaker	Marion
Jones, H. E.	Anderson	Madison
Jones, John C.	LaPorte	LaPorte
Jones, John Carl	Logansport	Cass
Jones, King Solomon	Michigan City	LaPorte
Jones, R. B.	LaPorte	LaPorte
Jones, W. W.	Frankfort	Clinton
Jordan, Leo E.	Lynn	Randolph
Joseph, Rex M.	Indianapolis	Marion
Jurgensen, Walter T.	Ft. Wayne	Allen

K

Name	City	County
Kabel, Robert N.	Terre Haute	Vigo
Kahan, H. L.	Gary	Lake
Kahler, M. V.	Indianapolis	Marion
Kahn, Alexander J.	Indianapolis	Marion
Kahn, Howard L.	Indianapolis	Marion
Kalb, Everett L.	Indianapolis	Marion
Kaler, James	Plymouth	Marshall
Kamm, Bernard A.	South Bend	St. Joseph
Kamman, G. H. (H)	Seymour	Jackson
Kammen, Leo	Indianapolis	Marion
Kammen, Robert	Indianapolis	Marion
Kammer, Grace C.	Muncie	Delaware-Blackford
Kammer, Walter F.	Muncie	Delaware-Blackford

Name	City	County
Kantzer, Floyd B.	Garrett	De Kalb
Karberg, Richard J.	Lafayette	Tippecanoe
Karn, John W.	South Bend	St. Joseph
Karpel, Bernard	Mooresville	Morgan
Karsell, W. A.	Bloomington	Owen-Monroe
Katterjohn, James C.	Indianapolis	Marion
Kauffman, Harley M.	Evansville	Vanderburgh
Kauffman, Nelson N.	Indianapolis	Marion
Kauffman, Sidney A.	Indianapolis	Marion
Kay, Oran	Spencer	Owen-Monroe
Keefe, Thomas L.	Logansport	Cass
Keeling, F. E.	Portland	Jay
Keeling, J. E. (H)	Waldron	Shelby
Keenan, R. L.	Indianapolis	Marion
Keever, C. H.	Indianapolis	Marion
Keiser, V. D.	Indianapolis	Marion
Keith, F. E. (H)	St. Bernice	Parke-Vermillion
Keller, F. G. (H)	Alexandria	Madison
Kelley, Clement E.	Indianapolis	Marion
Kelly, Don E.	Indianapolis	Marion
Kelly, Frank	Argos	Marshall
Kelly, J. F.	Indianapolis	Marion
Kelly, J. N.	LaPorte	La Porte
Kelly, W. C.	Anderson	Madison
Kelly, W. R.	Goshen	Elkhart
Kelly, Walter F.	Indianapolis	Marion
Kelly, William M.	Indianapolis	Marion
Kelsey, A. J.	Monterey	Pulaski
Kelsey, L. E.	Kewanna	Fulton
Kelsey, Robert M.	LaPorte	La Porte
Kemp, John T.	Michigan City	La Porte
Kemp, W. A.	Connersville	Fayette-Franklin
Kemper, A. T. (H)	Muncie	Delaware-Blackford
Kempf, G. F.	Indianapolis	Marion
Kendall, F. M.	Nappanee	Elkhart
Kendrick, Frank J.	Gary	Lake
Kendrick, W. M.	Indianapolis	Marion
Kennedy, Eva	Camden	Carroll
Kennedy, Hall	Indianapolis	Marion
Kennedy, H. F.	Indianapolis	Marion
Kennedy, R. O.	Rushville	Rush
Kennedy, W. U.	New Castle	Henry
Kenney, Francis D.	Rochester, Minn.	Lake
Kenoyer, Wilbur L.	New York, N. Y.	Marion
Kent, J. A.	Mulberry	Clinton
Kent, Richard N.	Ft. Wayne	Allen
Kenyon, C. E.	Cambridge City	Wayne-Union
Kepler, R. W.	La Porte	La Porte
Kern, C. B. (H)	Muncie	Delaware-Blackford
Kern, C. G.	Lebanon	Boone
Kerr, A. R.	Attica	Fountain-Warren
Kerr, Donald M.	Bedford	Lawrence
Kerr, Harry R.	Indianapolis	Marion
Kerrigan, R. L.	Michigan City	La Porte
Keseric, Nicholas E.	French Lick	Orange
Kessler, Robert B.	Evansville	Vanderburgh
Ketcham, Jane M.	Indianapolis	Marion
Ketcham, John S.	Rossville	Clinton
Kidd, James G.	Roann	Wabash
Kidder, J. J. (H)	Salamonia	Jay
Kidder, Orva T.	Ft. Wayne	Allen
Kiechle, Frederick L.	Evansville	Vanderburgh
Kilgore, Byron, Jr.	Indianapolis	Marion
Kim, C. H.	South Bend	St. Joseph
Kim, Young D.	Beech Grove	Marion
Kime, Charles E.	Richmond	Wayne-Union
Kime, E. N.	Indianapolis	Marion
Kime, J. T. (H)	Petersburg	Pike
Kindell, H. D.	New Richmond	Montgomery
King, B. A.	Anderson	Madison
King, Dale	Fairmount	Grant
King, Everett A.	Evansville	Vanderburgh
King, James R.	Silver Lake	Kosciusko
King, Joseph W.	Anderson	Madison
King, M. O.	Rochester	Fulton
King, P. C.	Swayzee	Grant
King, Robert W.	Cedar Lake	Lake
King, William E.	Indianapolis	Marion
King, William F.	Indianapolis	Marion
Kingsbury, J. K.	Indianapolis	Marion
Kinnaman, H. A.	Crawfordsville	Montgomery
Kinneman, R. E.	Greenfield	Hancock
Kintner, Burton E.	Elkhart	Elkhart
Kinzel, Robert J. W.	Indianapolis	Marion
Kinzie, M. Dale	Goshen	Elkhart
Kirch, L. N.	Evansville	Vanderburgh
Kirkhoff, Paul J.	Indianapolis	Marion
Kirklin, Oren L.	Indianapolis	Marion
Kirshman, F. E.	Muncie	Delaware-Blackford
Kirtley, J. M.	Crawfordsville	Montgomery
Kirtley, William R.	Indianapolis	Marion
Kiser, E. F.	Indianapolis	Marion
Kissinger, Charles C.	Fort Wayne	Marion
Kissinger, K. L.	Angola	Steuben
Kistler, James J.	La Porte	La Porte
Kistner, Arthur W.	Elkhart	Elkhart
Kitterman, Harry E.	Indianapolis	Marion
Klahr, Elsworth	South Bend	St. Joseph
Klain, B. V.	Indianapolis	Marion
Klamer, Charles H.	Jasper	Dubois
Klaus, J. M.	Crown Point	Lake
Kleindorfer, R. L.	Evansville	Vanderburgh
Kleinman, F. J.	Hebron	Porter
Klepinger, H. E.	Lafayette	Tippecanoe
Kling, Victor F.	Michigan City	La Porte
Klingler, Maurice O.	Plymouth	Marshall
Kloess, Edward J.	Mt. Clemens, Mich.	Marion
Knapp, Arthur L.	South Bend	St. Joseph
Kneidel, John H.	Indianapolis	Marion
Knepple, L. R. (H)	Kokomo	Howard
Knode, Kenneth T.	South Bend	St. Joseph
Knowles, Charles Y.	Indianapolis	Marion
Ko, Richard	Eaton	Delaware-Blackford
Kobrak, H. G.	Chicago, Ill.	Lake
Kobrin, Meyer W.	Gary	Lake
Koch, Elmer L.	Danville	Marion
Koehler, Elmer G.	Elkhart	Elkhart
Kohlstaedt, George	Indianapolis	Marion
Kohlstaedt, Karl C.	Indianapolis	Marion
Kohlstaedt, K. G.	Indianapolis	Marion
Kohne, C. J.	Decatur	Adams
Kohrman, Benj. M.	Michigan City	La Porte
Kolanko, Leon A.	Hammond	Lake
Kolettis, George J.	Gary	Lake
Komoroske, J. E.	East Chicago	Lake
Koons, Karl M.	Indianapolis	Marion
Koontz, William A.	Gas City	Grant
Kopanko, Bernard F.	East Chicago	Lake
Kopcha, Joseph E.	Gary	Lake
Kopecky, Robert R.	Indianapolis	Marion
Kopp, Herschel S.	Indianapolis	Marion
Kopp, O. A.	Anderson	Madison
Koransky, David S.	Hammond	Lake
Korn, Jerome M.	Gary	Lake
Kornafel, L. H.	Indianapolis	Marion
Kraft, Bennett	Indianapolis	Marion
Kraft, Haldon C.	Noblesville	Hamilton
Kramer, A. A.	South Bend	St. Joseph
Kraning, Kenneth	Kewanna	Fulton
Kratzer, E. F.	Kokomo	Howard
Kreischer, Joseph	Spencerville	De Kalb
Kresler, Leon	Rensselaer	Jasper-Newton

Name	City	County
Kretsch, R. W.	Hammond	Lake
Krieble, Wm. W.	Terre Haute	Vigo
Krieger, George M.	Michigan City	La Porte
Kron, R. Vincent	East Gary	Lake
Krueger, Frederick W.	Richmond	Wayne-Union
Kruse, E. H.	Fort Wayne	Allen
Kruse, Walter E.	Fort Wayne	Allen
Kubik, Francis J.	Michigan City	La Porte
Kubley, James D.	Plymouth	Marshall
Kudele, L. T.	Whiting	Lake
Kuder, Howard V.	Muncie	Delaware-Blackford
Kuhn, Frederick L.	South Bend	St. Joseph
Kuhn, Hedwig S.	Hammond	Lake
Kuhn, Hugh A.	Hammond	Lake
Kuhn, R. W.	Wilkinson	Hancock
Kunkler, Joseph	Terre Haute	Vigo
Kunkler, Wm. C.	Terre Haute	Vigo
Kuntz, Herman W.	Indianapolis	Marion
Kurtz, Fred B.	Indianapolis	Marion
Kurtz, Philip L.	Indianapolis	Marion
Kurtz, William A.	Tipton	Tipton
Kwitny, I. J.	Indianapolis	Marion

L

Name	City	County
LaBier, C. Russell	Terre Haute	Vigo
LaBier, Clarence R. (H)	Terre Haute	Vigo
Ladig, Donald S.	Fort Wayne	Allen
LaDine, C. B.	Indianapolis	Marion
LaDuron, Jules F.	Muncie	Delaware-Blackford
LaFollette, Forrest R.	Whiting	Lake
LaFollette, Robert E.	New Albany	Floyd
Laird, L. A.	Richmond	Wayne-Union
Lamb, E. B.	Indianapolis	Marion
Lamb, Russell	Indianapolis	Marion
Lamber, C. K.	Indianapolis	Marion
Lambert, C. W.	Los Angeles, Calif.	Marion
Lamey, James L.	Anderson	Madison
Lamey, P. T.	Anderson	Madison
Lancet, Robert O.	Terre Haute	Vigo
Lane, W .H. (H)	Angola	Steuben
Lane, Wm. H.	South Bend	St. Joseph
Lang, Joseph E.	South Bend	St. Joseph
Lang, Shirley C.	Evansville	Vanderburgh
Langdon, H. K. (H)	Indianapolis	Marion
Langenbahn, C. J.	South Bend	St. Joseph
Langohr, John	Columbia City	Whitley
Langsdon, Fred	Gaston	Delaware-Blackford
Lansford, John	Redkey	Jay
Laramore, Ward	Indianapolis	Marion
Larkin, Bernard J.	Indianapolis	Marion
Laramore, Ward	La Porte	La Porte
Larmore, J. L.	Anderson	Madison
Larmore, Sarah H.	Anderson	Madison
LaRocca, Joseph	Valparaiso	Porter
Larrabee, James F.	Hammond	Lake
Larrabee, W. H. (H)	New Palestine	Hancock
Larrison, G. D.	Morocco	Jasper-Newton
Larson, G. O.	La Porte	La Porte
Larson, John A.	Logansport	Cass
LaSalle, R. M.	Wabash	Wabash
Lashley, Donald L.	Tell City	Perry
Laubscher, Clarence	Evansville	Vanderburgh
Laudeman, W. A.	Elwood	Madison
Lauer, D. B.	Dana	Parke-Vermillion
Lava, Irving M.	Michigan City	La Porte
Lavengood, R. W.	Marion	Grant
Lawler, George F.	Indianapolis	Marion
Lawrence, Edwin A.	Indianapolis	Marion
Lawrence, Joseph C.	Evansville	Vanderburgh
Laws, H. J.	Lafayette	Tippecanoe
Laws, Kenneth F.	Lafayette	Tippecanoe
Lawson, I. H.	Kendallville	Noble
Layman, Daniel W. (H)	Indianapolis	Marion
Leak, Robert H.	Boswell	Benton
Leasure, J. K.	Indianapolis	Marion
Leasure, Kenneth	Etna Green	Kosciusko
Leatherman, H. L.	Indianapolis	Marion
Lebioda, Henry S.	Gary	Lake
Lee, A. H.	Terre Haute	Vigo
Lee, Glen Ward	Richmond	Wayne-Union
Leff, Abe	Indianapolis	Marion
Leffel, James M.	Indianapolis	Marion
Lehman, Harold	Berne	Adams
Lehman, Kenneth M.	Topeka	LaGrange
Lehman, Robert J.	Long Island, N. Y.	Marion
Lehmberg, O. F.	Columbia City	Whitley
Lehner, John H.	Fort Wayne	Allen
Leich, Charles F.	Evansville	Vanderburgh
Leiter, Arthur	Indianapolis	Whitley
Lemon, Herbert K.	Logansport	Elkhart
Lenk, George G.	Fort Wayne	Allen
Leonard, Henry S. (H)	Indianapolis	Marion
Leser, R. U.	Indianapolis	Marion
Leslie, Ermil	Evansville	Vanderburgh
Lett, Emory B.	Loogootee	Daviess-Martin
Levi, Leon	Indianapolis	Marion
Levin, Eli	East Chicago	Lake
Levin, Ralph T.	Indianapolis	Marion
Lewis, James F.	Liberty	Wayne-Union
Lewis, Robert J.	Lawrence	Marion
Lichtenberg, Melvin	Indianapolis	Marion
Lidikay, Edward C.	Indianapolis	Marion
Life, Homer	New Castle	Henry
Lindenborg, Paul G.	Indianapolis	Marion
Lindsay, H. B.	Washington	Daviess-Martin
Line, H. E.	Chili	Miami
Ling, John F.	Richmond	Wayne-Union
Lingeman, Byron N.	Crawfordsville	Montgomery
Lingeman, Raleigh E.	Indianapolis	Marion
Lingeman, Roger	Indianapolis	Delaware-Blackford
Link, Goethe	Indianapolis	Marion
Linn, E. E.	La Porte	La Porte
Linton, C. D.	Walkerton	St. Joseph
Linton, C. E.	Medaryville	Pulaski
Lionberger, John R.	South Bend	St. Joseph
Lippoldt, Charles L.	Batesville	Ripley
Liss, Emanuel C.	South Bend	St. Joseph
List, Harold E.	Glenview, Ill.	Grant
Littell, J. J.	Indianapolis	Marion
Little, John W. (H)	Indianapolis	Marion
Little, Wm. J.	Bicknell	Knox
Litzenberger, S. W.	Anderson	Madison
Lloyd, John T.	Bluffton	Wells
Lloyd, Robert P.	Ft. Wayne	Allen
Lochry, R. L.	Indianapolis	Marion
Lockhart, Jack M.	Connersville	Fayette-Franklin
Lockhart, Philip B.	Indianapolis	Marion
Loehr, W. M.	Indianapolis	Marion
Loewenstein, W. L.	Terre Haute	Vigo
Logan, A. R.	Petersburg	Pike
Logan, F. W.	Mishawaka	St. Joseph
Logan, James Z.	Richmond	Wayne-Union
Logan, Jesse R.	Evansville	Vanderburgh
Lohman, Robert M.	Fort Wayne	Allen
Lomax, Claude	Dale	Marion
Long, Max	Marion	Grant
Long, Paul L.	Anderson	Madison
Loomis, N. S.	Indianapolis	Marion
Loop, Floyd A.	Lafayette	Tippecanoe
Loop, Frederick A.	Lafayette	Tippecanoe
Lord, G. C.	Indianapolis	Marion
Lorenty, T. B.	Gary	Lake
Loring, Mark L.	Valparaiso	Porter

Name	City	County
Lorman, James G.	Indianapolis	Marion
Loudermilk, J. L.	Ft. Wayne	Allen
Love, George N.	Indianapolis	Marion
Love, John R.	Terre Haute	Vigo
Lovell, Martin H.	Gary	Lake
Lovett, H. D.	Whitestown	Boone
Loving, J. B.	New Goshen	Vigo
Luckett, Coen L.	Terre Haute	Vigo
Luckey, H. A.	Wolf Lake	Noble
Luckey, R. C.	Wolf Lake	Noble
Ludwick, Harry	South Bend	St. Joseph
Ludwig, Oscar D.	Indianapolis	Marion
Lukemeyer, Geo. T.	Indianapolis	Marion
Lukemeyer, L. C. (H)	Huntingburg	Dubois
Lukenbill, Emery D.	Indianapolis	Marion
Lundeberg, Ralph A.	Griffith	Lake
Lundt, Milo O.	Elkhart	Elkhart
Lung, B. D.	Kokomo	Howard
Lutes, D. L.	Edinbudg	Johnson
Luthy, Karl R.	South Bend	St. Joseph
Lutz, Georgianna	Gary	Lake
Luzadder, J. E. (H)	Bloomington	Owen-Monroe
Luzadder, J. C., Jr.	New Carlisle	St. Joseph
Lybrook, D. E.	Young America	Cass
Lybrook, William B.	Indianapolis	Marion
Lynch, Harold D.	Evansville	Vanderburgh
Lynch, Otis R.	Marengo	Crawford
Lynch, Paul	Evansville	Vanderburgh
Lynn, F. M. (H)	Peru	Miami
Lyon, Florence	Portland	Jay
Lyons, R. E., Jr.	Bloomington	Owen-Monroe

M

Name	City	County
MacDonald, J. A.	Indianapolis	Marion
Macer, Clarence G.	Evansville	Vanderburgh
Machledt, J. H.	Whiteland	Johnson
MacKenzie, Pierce	Evansville	Vanderburgh
Mackey, Harry S.	Indianapolis	Marion
Mackey, John E.	Indianapolis	Marion
Macy, George W.	Columbus	Bartholomew-Brown
Mader, John H.	Richmond	Wayne-Union
Madtson, A. Ricks	Indianapolis	Marion
Magennis, H. L.	Indianapolis	Marion
Mahoney, Charles L.	Terre Haute	Vigo
Mahuron, Boyd L.	Greensburg	Decatur
Majsterek, S. L.	Gary	Lake
Makovsky, Theodore	Valparaiso	Porter
Malcolm, Russell	Richmond	Wayne-Union
Malmstone, F. A.	Griffith	Lake
Malone, L. A.	Terre Haute	Vigo
Malott, Fred	Converse	Miami
Malouf, S. D.	Peru	Miami
Manalan, Maurice M.	Indianapolis	Marion
Manifold, Harold M.	Fortville	Hancock
Manion, Marlow W.	Indianapolis	Marion
Manley, Chas. N.	Rising Sun	Dearborn-Ohio
Mann, Mortimer	Indianapolis	Marion
Manning, Joseph C.	Indianapolis	Marion
Manning, K. R.	Indianapolis	Marion
Manuel, Donald	Franklin	Johnson
Manzie, Michael	Lyons	Greene
Maple, J. B.	Sullivan	Sullivan
Marchand, Austin F.	Haubstadt	Gibson
Marchand, Edwin V.	Haubstadt	Gibson
Marchant, Clarence H.	Bloomington	Owen-Monroe
Marcus, Emanuel	Hammond	Lake
Marcus, M. C.	Gary	Lake
Maris, Lee J.	Attica	Fountain-Warren
Markel, I. J.	Elkhart	Elkhart
Markey, R. J. P.	Hammond	Lake
Markle, Joseph G.	Hammond	Lake
Marks, H. H.	Huntington	Huntington
Marks, Ora L.	East Chicago	Lake
Marks, Salvo P.	Hammond	Lake
Marr, Griffith	Columbus	Bartholomew-Brown
Marsh, Chester A.	Hagerstown	Henry
Marsh, George W.	Lafayette	Tippecanoe
Marshall, Albert L., Jr.	Indianapolis	Marion
Marshall, C. R.	Indianapolis	Marion
Marshall, George L.	Bourbon	Marshall
Marshall, Millard R.	Whiting	Lake
Martin, C. E.	Lynn	Randolph
Martin, Charles F.	Indianapolis	Marion
Martin, Floyd S.	Goshen	Elkhart
Martin, Frank D.	Bedford	Lawrence
Martin, Guy	Seymour	Jackson
Martin, Hugh E.	Indianapolis	Marion
Martin, H. G.	Lafayette	Tippecanoe
Martin, Joe M	Lafayette	Tippecanoe
Martin, Loren H.	Indianapolis	Marion
Martin, W. B.	La Porte	La Porte
Martineau, Perry C.	Ft. Wayne	Allen
Martz, Bill L.	Indianapolis	Marion
Martz, Carl D.	Indianapolis	Marion
Marvel, Robert J.	Indianapolis	Marion
Maschmeyer, R. H.	Shoals	Daviess-Martin
Mason, Bernard	South Bend	St. Joseph
Mason, Donald G.	Angola	Steuben
Mason, Everett E.	Evansville	Vanderburgh
Mason, Lester M.	Terre Haute	Vigo
Mason, L. R.	Muncie	Delaware-Blackford
Masters, John B.	San Luis Obispo, Cal.	Marion
Masters, John M.	Indianapolis	Marion
Masters, R. J.	Indianapolis	Marion
Mather, Robert	Indianapolis	Marion
Mather, J. W.	East Gary	Lake
Mathews, W. C.	Kentland	Jasper-Newton
Mathys, Alfred	Mauckport	Harrison
Matthew, John R.	North Judson	Starke
Matthew, W. B.	Indianapolis	Marion
Matthews, B. J.	Indianapolis	Marion
Matthews, Chas. B. (H)	Hammond	Lake
Matthews, D. W.	North Vernon	Jennings
Matthews, William M.	Indianapolis	Marion
Mattox, Don M.	Terre Haute	Vigo
Maurer, J. F.	Brazil	Clay
Maurer, Robert M.	Brazil	Clay
Maxon, Roy V.	Indianapolis	Marion
Maxwell, J. B. (H)	Logansport	Cass
May, George A.	Madison	Jefferson
May, R. Milton.	Gary	Lake
Mayfield, C. H.	Reynolds	Tippecanoe
McAdams, Hugh B.	Lafayette	Tippecanoe
McArdle, Edward G.	Ft. Wayne	Allen
McBride, James S.	Indianapolis	Marion
McBride, Noel S.	Terre Haute	Vigo
McCabe, J. E.	Otterbein	Benton
McCabe, Theodore E.	Ft. Wayne	Allen
McCallum, J. T. C.	Indianapolis	Marion
McCarthy, Daniel J. (H)	Indianapolis	Marion
McCarthy, Jeremiah A.	Whiting	Lake
McCartney, Donald H.	Indianapolis	Marion
McCarty, Virgil	Princeton	Gibson
McCaskey, C. H.	Indianapolis	Marion
McCaskey, G. H.	Winamac	Pulaski
McClain, Marvin	Scottsburg	Scott
McClellan, John B.	Muncie	Delaware-Blackford
McClelland, D. C.	Lafayette	Tippecanoe
McClelland, Mary E.	Bloomington	Owen-Monroe
McClintock, James A.	Muncie	Delaware-Blackford
McClure, S. E.	Monon	Tippecanoe

Name	City	County
McConnell, Wm. C.	Sunman	Ripley
McCool, J. H.	Evansville	Vanderburgh
McCool, W. E. (H)	Evansville	Venderburgh
McCord, C. B.	Veedersburg	Fountain-Warren
McCormick, C. O., Jr.	Indianapolis	Marion
McCormick, C. O., Sr.	Indianapolis	Marion
McCormick, H. D.	Vincennes	Knox
McCormick, W. C.	Terre Haute	Vigo
McCown, P. E.	Indianapolis	Marion
McCoy, George E.	Muncie	Delaware-Blackford
McCoy, Roy R.	Ft. Wayne	Allen
McCracken, J. O.	Montgomery	Daviess-Martin
McCraley, William J.	South Bend	St. Joseph
McCullough, J. Y.	New Albany	Floyd
McDaniel, F. P.	Atlanta	Hamilton
McDevitt, D. R.	Indianapolis	Marion
McDonald, Frank C.	New Castle	Henry
McDonald, J. D.	University City, Mo.	Vanderburgh
McDonald, R. M.	South Bend	St. Joseph
McDonald, V. G.	Anderson	Madison
McDowell, George A.	Ft. Wayne	Allen
McDowell, M. M.	Vincennes	Knox
McEachern, Cecil	Ft. Wayne	Allen
McElroy, J. S.	New Castle	Henry
McElroy, R. S.	Princeton	Gibson
McEwen, J. W.	Terre Haute	Vigo
McFadden, James M.	Lafayette	Tippecanoe
McFarland, Corley B.	South Bend	St. Joseph
McGrath, Michael F.	Indianapolis	Marion
McGuff, Paul	Indianapolis	Marion
McGuire, D. F.	East Chicago	Lake
McIlroy, Richard J.	Claypool	Kosciusko
McIlwain, Eleanor	Marion	Grant
McIlwain, Robert	Marion	Grant
McIndoo, R. E.	Kokomo	Howard
McIntire, Clarence R.	Indianapolis	Marion
McIntosh, Wilbert (H)	Riley	Vigo
McIntyre, Charles J.	Indianapolis	Marion
McIntyre, J. M.	Indianapolis	Marion
McKay, Robert	Indianapolis	Wabash
McKee, C. E. (H)	Dublin	Wayne-Union
McKee, Horace N.	Elkhart	Elkhart
McKee, H. S.	Greensburg	Decatur
McKeeman, D. H.	Ft. Wayne	Allen
McKeeman, L. S.	Ft. Wayne	Allen
McKenna, H. J.	South Bend	St. Joseph
McKinley, A. D.	Indianapolis	Marion
McKinney, D. H.	Lafayette	Tippecanoe
McKittrick, Jack	Washington	Daviess-Martin
McLaughlin, C. P.	Pendleton	Madison
McLaughlin, G. C.	Terre Haute	Vigo
McLaughlin, James R.	Flora	Carroll
McLean, James S.	Hammond	Lake
McLelland, Mary R.	Bloomington	Owen-Monroe
McMahan, Virgil	Vincennes	Knox
McMeel, J. E.	South Bend	St. Joseph
McMichael, F. J.	Gary	Lake
McMichael, R. M.	Muncie	Delaware-Blackford
McMillan, F. G.	Indianapolis	Marion
McNabb, G. B.	Carthage	Rush
McNairy, Donald J.	Ft. Wayne	Allen
McNamara, John P.	Indianapolis	Marion
McNaughton, L. M.	Washington	Daviess-Martin
McNeely, M. J.	Dillsboro	Dearborn-Ohio
McQuiston, R. J.	Indianapolis	Marion
McTurnan, Robert W.	Indianapolis	Marion
McVaugh, Charles C.	Chicago, Ill.	Madison
McWilliams, W. B.	Liberty	Wayne-Union
Mead, C. H.	Bluffton	Wells
Meade, Walter W.	Bicknell	Knox
Megenhardt, D. S.	Indianapolis	Marion
Mehl, Rudolph A.	Evansville	Vanderburgh
Meihaus, John E.	Los Angeles, Calif.	Marion
Meikle, Louise J.	W. Lafayette	Tippecanoe
Meiks, Lyman T.	Indianapolis	Marion
Meiner, J. A.	Kokomo	Howard
Meiser, Robert	Huntington	Huntington
Meister, Doris	Anderson	Madison
Melloh, A. F.	Indianapolis	Marion
Mendenhall, Clarence D.	Indianapolis	Marion
Mendenhall, Edgar	Ft. Wayne	Allen
Mendenhall, W. E.	Indianapolis	Marion
Mendez, Carlos	Elkhart	Elkhart
Mentendiek, M. H.	Indianapolis	Marion
Mercer, Herman	Jeffersonville	Clark
Mercer, Samuel R.	Ft. Wayne	Allen
Meredith, E. J.	Richmond	Wayne-Union
Mericle, Earl W.	Indianapolis	Marion
Merrell, B. M.	Rockville	Parke-Vermillion
Merrell, Paul	Indianapolis	Marion
Mertz, H. O.	Indianapolis	Marion
Messer, F. W.	Kendallville	Noble
Metcalf, George B.	Anderson	Madison
Metcalfe, G. E.	South Bend	St. Joseph
Mettler, Don C.	Auburn	De Kalb
Meyer, Herman A.	Ft. Wayne	Allen
Meyer, K. T.	Evansville	Vanderburgh
Meyer, Milo G.	Michigan City	La Porte
Meyer, Orlando L.	Bedford	Lawrence
Meyer, R. C.	Vincennes	Knox
Meyer, Theodore O.	Ft. Wayne	Allen
Meyn, Werner P.	Terre Haute	Vigo
Michael, Amos C.	Indianapolis	Marion
Michael, Isaac E.	Frankfort	Clinton
Michaelis, S. C.	Ft. Wayne	Allen
Micheli, A. J.	Indianapolis	Marion
Middleton, H. N.	Indianapolis	Marion
Middleton, Thomas O.	Bloomington	Owen-Monroe
Mikesch, W. H.	South Bend	St. Joseph
Miklozek, John E.	Terre Haute	Vigo
Miley, Weir M.	Anderson	Madison
Miller, Albert W.	Indianapolis	Marion
Miller, Carl G.	Ft. Wayne	Allen
Miller, Charles A. (H)	Princeton	Gibson
Miller, D. B.	Terre Haute	Vigo
Miller, E. H.	Valparaiso	Porter
Miller, Frank	Morristown	Shelby
Miller, H. Allison	Marion	Grant
Miller, H. L.	West Baden	Orange
Miller, Harold E.	Seymour	Jackson
Miller, H. Paul	Ft. Wayne	Allen
Miller, Hugh A.	Elkhart	Elkhart
Miller, Iva M.	Indianapolis	Marion
Miller, J. Don	Indianapolis	Marion
Miller, James C.	Greensburg	Decatur
Miller, John R.	Indianapolis	Marion
Miller, L. R.	Winslow	Pike
Miller, LaVerne B.	Evansville	Vanderburgh
Miller, M. E.	Goshen	Elkhart
Miller, Mahlon F.	Ft. Wayne	Allen
Miller, Mary E.	Bloomington	Owen-Monroe
Miller, Milton	Evansville	Vanderburgh
Miller, Milo	South Bend	St. Joseph
Miller, Minor	Evansville	Vanderburgh
Miller, Orval J.	Ft. Wayne	Allen
Miller, R. S.	Indianapolis	Marion
Miller, Ray D.	Indianapolis	Marion
Miller, Richard C.	Shelbyville	Shelby
Miller, Richard H.	Ft. Wayne	Allen
Miller, Robert J.	Evansville	Vanderburgh
Miller, Roland E.	Lafayette	Tippecanoe
Miller, S. J.	W. Lafayette	Tippecanoe
Miller, S. T.	Elkhart	Elkhart
Miller, Virgil	Akron	Fulton

Name	City	County
Miller, Wm. A.	Hagerstown	Henry
Miller, Wm. E.	South Bend	St. Joseph
Miller, Wm. J.	Ft. Wayne	Allen
Millikan, William	Indianapolis	Marion
Mills, Fred E.	Evansville	Vanderburgh
Mills, J. F.	Wabash	Wabash
Minczewski, Richard C.	Gary	Lake
Mininger, Edward P.	Elkhart	Elkhart
Mino, Victor H.	Evansville	Vanderburgh
Mishkin, Irving	Elkhart	Elkhart
Mitchell, Albert M.	Terre Haute	Vigo
Mitchell, E. T.	Romney	Tippecanoe
Mitchell, Earl H.	Indianapolis	Marion
Mitchell, G. L.	Smithville	Owen-Monroe
Mitchell, R. E.	Springfield, Missouri	Marion
Mitman, F. B.	Huntington	Huntington
Moats, C. F.	Ft. Wayne	Allen
Moats, G. E.	Ft. Wayne	Allen
Modjeski, Joseph R.	Hammond	Lake
Modjeski, Raymond J.	Hammond	Lake
Moehlenkamp, C. E.	Evansville	Vanderburgh
Moenning, W. P.	Indianapolis	Marion
Mohler, Floyd W.	South Bend	Marion
Mohr, Ann L. M.	West Terre Haute	Vigo
Molengraft, C. J.	Gary	Lake
Molloy, W. J. (H)	Muncie	Delaware-Blackford
Molt, W. F.	Indianapolis	Marion
Monroe, F. Bruce	Crown Point	Lake
Montgomery, J. R.	Owensville	Gibson
Montgomery, L. G.	Muncie	Delaware-Blackford
Montgomery, S. B. (H)	Cynthiana	Posey
Montgomery, Wm. F.	Indianapolis	Marion
Moore, B. B.	Indianapolis	Marion
Moore, Edwin G.	Gary	Lake
Moore, E. Gregory	Gary	Lake
Moore, H. T.	Indianapolis	Marion
Moore, R. G.	Vincennes	Knox
Moore, Robert M.	Indianapolis	Marion
Moore, Thomas C.	Indianapolis	Delaware-Blackford
Moore, W. C.	Muncie	Delaware-Blackford
Moosey, Louis	Union Mills	LaPorte
Moran, Mark M.	Portland	Jay
Moran, Noel D.	Versailles	Ripley
Moravec, Arthur E.	Ft. Wayne	Allen
Morchan, Samuel	Indianapolis	Marion
Morec, George J.	Indianapolis	Marion
Morford, Guy	Indianapolis	Howard
Morgan, S. P.	LaPorte	LaPorte
Moriarty, John R.	Indianapolis	Marion
Morr, J. W. (H)	Albion	Noble
Morrical, Russell J.	Logansport	Cass
Morris, Hyman	Gary	Lake
Morris, J. W.	Muncie	Delaware-Blackford
Morris, Robert A.	Anderson	Madison
Morris, Warren V.	Monticello	Tippecanoe
Morrison, C. C. (H)	Greensburg	Decatur
Morrison, G. G.	Portland	Jay
Morrison, John S. (H)	Lafayette	Tippecanoe
Morrison, J. T.	Greensburg	Decatur
Morrison, Lindsey (H)	Hammond	Lake
Morrison, Lewis E. II	Indianapolis	Marion
Morrison, W. R.	Kokomo	Howard
Morrow, George W.	Logansport	Cass
Morrow, R. D.	Connersville	Fayette-Franklin
Mortenson, L. J.	Ft. Wayne	Allen
Morton, Walter P.	Indianapolis	Marion
Moser, E. B.	Windfall	Tipton
Moser, Edward	Woodburn	Allen
Moser, R. H.	Indianapolis	Marion
Moses, George E.	Worthington	Greene
Moses, Robert E.	Worthington	Greene
Moss, Harlan B.	Indianapolis	Lake
Moss, M. J.	Yorktown	Delaware-Blackford
Mothersill, M. H.	Indianapolis	Marion
Mott, C. A.	South Bend	St. Joseph
Moulton, Lillian	Indianapolis	Marion
Mount, M. S.	Bloomfield	Greene
Mount, Wm. M.	Crawfordsville	Montgomery
Mountain, Francis	Connersville	Fayette-Franklin
Mozingo, A. E.	Indianapolis	Marion
Muelchi, Adeline F.	Evansville	Vanderburgh
Mueller, Lawrence W.	Ft. Wayne	Allen
Mueller, Lillian B.	Indianapolis	Marion
Muhleman, C. E.	LaPorte	LaPorte
Mull, P. L. (H)	Louisville, Ky.	Washington
Muller, Lullus P.	Indianapolis	Benton
Muller, Paul F.	Indianapolis	Marion
Mullikin, C. W.	Greensburg	Decatur
Mumford, E. B.	Indianapolis	Marion
Munk, C. E.	Kendallville	Noble
Murdock, H. L.	Ft. Wayne	Allen
Murphy, E. C.	South Bend	St. Joseph
Murphy, E. W.	New Albany	Harrison
Murphy, George M.	Franklin	Johnson
Murphy, Harry	Franklin	Johnson
Murphy, Joseph F., Jr.	Hammond	Lake
Murphy, Josephine	South Bend	St. Joseph
Murphy, M. G.	Morgantown	Morgan
Murray, Ernest C.	Kokomo	Howard
Murray, Jas. S., Jr.	Baltimore, Md.	Marion
Musacchio, Frederick A.	Hammond	Lake
Musselman, G. G.	Terre Haute	Vigo
Myers, B. D. (H)	Bloomington	Owen-Monroe
Myers, Charles W.	Indianapolis	Marion
Myers, Harold Allen	Indianapolis	Marion
Myers, R. V.	Indianapolis	Marion
Myers, Wm. C.	Dana	Parke-Vermillion

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Name	City	County
Nafe, C. A.	Indianapolis	Marion
Nahrwold, Elmer W.	Ft. Wayne	Allen
Nakadate, Katsumi J.	East Chicago	Lake
Nance, W. K.	Vincennes	Knox
Napper, Floyd	Scottsburg	Scott
Nash, Charles B.	Valparaiso	Porter
Nash, Justin R.	Albion	Noble
Nason, R. A.	Garrett	DeKalb
Nassef, George	Walkerton	Marshall
Naugle, R. A.	Wabash	Wabash
Nave, H. E.	Fountaintown	Shelby
Navin, Hugh K.	Fortville	Hancock
Nay, E. O.	Terre Haute	Vigo
Nay, Richard M.	Indianapolis	Lake
Neal, Leonard W.	Hammond	Marion
Neale, Alfred E.	Anderson	Madison
Need, Louis T.	Indianapolis	Marion
Neely, A. S.	Indianapolis	Marion
Nehil, L. W.	Indianapolis	Marion
Neidballa, E. G.	Bristol	Elkhart
Neier, O. C. (H)	Indianapolis	Marion
Neifert, Noel	Tell City	Perry
Nelson, Carl A.	West Lebanon	Fountain-Warren
Nelson, F. Dale	South Bend	St. Joseph
Nelson, Paul Leon	Anderson	Madison
Nelson, R. B.	Hammond	Lake
Nelson, Raymond	South Bend	St. Joseph
Nelson, Walfred A.	Gary	Lake

Name	City	County
Nenneker, Henry (H)	Evansville	Vanderburgh
Nesbit, L. L.	Anderson	Madison
Nesbit, O. B. (H)	Gary	Lake
Nester, Henry G.	Indianapolis	Marion
Netherton, C. R.	Chalmers	Tippecanoe
Neucks, Howard C.	Evansville	Vanderburgh
Neukamp, Frank H.	Connersville	Fayette-Franklin
Neumann, K. O.	Lafayette	Tippecanoe
Neuwalt, Frank	Gary	Lake
Newby, A. C.	Sheridan	Hamilton
Newby, Eugene	Sheridan	Hamilton
Newcomb, Wm. K.	Royal Center	Cass
Newland, A. E.	Bedford	Lawrence
Newman, A. E.	Evansville	Vanderburgh
Niblack, E. S. (H)	Manhasset, N. Y.	Vigo
Niblack, J. S.	East Chicago	Lake
Nichols, Anne Sackett	Greencastle	Putnam
Nichols, Wm. E. (H)	Hammond	Lake
Nickel, Allen C.	Bluffton	Wells
Nicosia, J. B.	East Chicago	Lake
Nie, Grover	Huntington	Huntington
Nie, Louis W.	Indianapolis	Marion
Niedermayer, Alfred	Evansville	Vanderburgh
Nigh, R. M.	Fairland	Shelby
Nill, John H.	Ft. Wayne	Allen
Nisenbaum, Harold	Evansville	Vanderburgh
Nixon, Byron	Farmland	Randolph
Noble, T. B., Jr.	Indianapolis	Marion
Nodinger, Louis	Hammond	Lake
Noe, Wm. R.	Indianapolis	Marion
Nolan, Robert E.	English	Orange
Nolt, E. V.	Columbia City	Whitley
Nolting, H. F.	Indianapolis	Marion
Nonte, Leo R.	Indianapolis	Marion
Norman, Wm. H.	Indianapolis	Marion
Norman, O. B.	Indianapolis	Marion
Norris, Allen A.	Elkhart	Elkhart
Norris, Ernest B.	Middlebury	Elkhart
Norris, H. L.	Indianapolis	Marion
Norris, Mary A.	Indianapolis	Marion
Norton, H. J.	Columbus	Bartholomew-Brown
Norton, Horace	Washington	Daviess-Martin
Norwick, Sydney	San Lorenzo, Calif.	Marion
Nourse, Myron H.	Indianapolis	Marion
Nugen, Harold	Auburn	DeKalb
Nugent, Edwin J.	Indianapolis	Marion
Nutter, Wyndham H.	Rushville	Rush

O

Name	City	County
Oak, David	Hanna	LaPorte
Oak, D. D.	La Crosse	LaPorte
Obery, George	Batesville	Ripley
Ochsner, Harold C.	Indianapolis	Marion
Ockerman, Kenneth R.	Demotte	Jasper-Newton
O'Conner, James J.	East Chicago	Lake
O'Dell, Harry C.	Farmersburg	Sullivan
O'Dell, Harry W.	Cleveland, O.	Sullivan
Olcott, C. W.	Aurora	Dearborn-Ohio
O'Leary, F. T.	Logansport	Cass
Oliphant, F. W.	Mount Vernon	Posey
Oliphant, J. T.	Farmersburg	Sullivan
Oliphant, R. W.	Terre Haute	Vigo
Olney, Thomas A. (H)	South Bend	St. Joseph
Olson, K. L.	South Bend	St. Joseph
Olvey, Ottis N.	Indianapolis	Marion
Omstead, Milton	Petersburg	Pike
Omstead, Trevalyn W.	Huntington	Huntington
O'Neil, Martin J.	Rensselaer	Jasper-Newton
Openshaw, J. F.	Goodland	Jasper-Newton
Oppenheimer, Ernst	Evansville	Vanderburgh
Orders, C. E.	Indianapolis	Marion
Ornelas, Joseph P.	Gary	Lake
O'Rourke, Carroll	Ft. Wayne	Allen
Orr, Wm. Robert	Mishawaka	St. Joseph
Osborne, Harry S.	Roachdale	Marion
Oster, Ellis	Randolph Field, Tex.	Delaware-Blackford
Osterman, Louis	Seymour	Jackson
Oswald, Robert H.	Indianapolis	Marion
Oswalt, James T.	Mitchell	Lawrence
Otten, Claude F.	Indianapolis	Marion
Otten, Ralph E.	Darlington	Montgomery
Ottinger, R. C.	Indianapolis	Marion
Overman, F. V.	Tipton	Tipton
Overpeck, Charles	Greensburg	Decatur
Overpeck, George H.	Alexandria	Madison
Overshiner, Lyman	Columbus	Bartholomew-Brown
Owen, Abraham	Bloomington	Owen-Monroe
Owen, J. E.	Indianapolis	Marion
Owen, Margaret A.	Bloomington	Owen-Monroe
Owens, Richard R.	Muncie	Delaware-Blackford
Owens, Thomas R.	Muncie	Delaware-Blackford
Owens, Tracy	Indianapolis	Marion
Owens, Walter Lee	Bloomington	Owen-Monroe
Owsley, Charlotte M.	Hartford City	Delaware-Blackford
Owsley, Guy A.	Hartford City	Delaware-Blackford
Oyer, J. H.	Ft. Wayne	Allen

P

Name	City	County
Pace, J. V.	New Albany	Floyd
Padgett, Everett	Indianapolis	Marion
Paff, W. A.	Elkhart	Elkhart
Pahmeier, J. W.	Sandborn	Knox
Paine, George E.	Elkhart	Elkhart
Painter, Donald S.	Ft. Wayne	Allen
Painter, L. W.	Winchester	Randolph
Palm, John M.	Brazil	Clay
Palmer, Russell H.	Gary	Lake
Panares, Solomon V.	Hammond	Lake
Pancost, Ruth Hoetzer	Elkhart	Elkhart
Pancost, Vernon K.	Elkhart	Elkhart
Pandolfo, Harry	Indianapolis	Marion
Paris, D. W.	Kokomo	Howard
Paris, J. M.	New Albany	Floyd
Parke, D. Davis	South Bend	St. Joseph
Parker, Carl B.	Wingate	Montgomery
Parker, C. B.	Ft. Wayne	Allen
Parker, E. E.	Oxford	Benton
Parker, G. F.	Greencastle	Putnam
Parker, Geo. F., Jr.	Indianapolis	Marion
Parker, H. C.	Gary	Lake
Parker, J. F.	Indianapolis	Marion
Parker, Portia	Indianapolis	Marion
Parks, George A.	Hartford City	Delaware-Blackford
Parratt, Louis W.	Gary	Lake
Parrish, Richard K.	Decatur	Adams
Pastor, Julius W.	Evansville	Vanderburgh
Patrick, G. B.	Elkhart	Elkhart
Patten, V. C. (H)	Morristown	Shelby
Patterson, Cecil L.	Charlestown	Clark
Patterson, Wm. K.	Anderson	Madison

Name	City	County
Patton, Martin T.	Indianapolis	Marion
Paul, Wm. Thomas F.	Hammond	Lake
Paulissen, George T.	Indianapolis	Marion
Pauszek, Thomas B.	South Bend	St. Joseph
Paynter, L. W. (H)	Salem	Washington
Paynter, Morris B.	Southport	Marion
Peacock, Robert	Indianapolis	Marion
Pearce, Roy V.	Terre Haute	Vigo
Pearlman, Samuel	Lafayette	Tippecanoe
Pearson, John R.	Bedford	Lawrence
Pearson, Lyman R.	Indianapolis	Marion
Pebworth, A. C.	Indianapolis	Marion
Pebworth, J. T.	Silver City, N. M.	Marion
Peck, Franklin B.	Indianapolis	Marion
Peck, James F.	Princeton	Gibson
Peirce, James D.	Indianapolis	Marion
Pence, Benjamin F.	Columbia City	Whitley
Pennington, W. E.	Indianapolis	Marion
Permer, Erwin	Indianapolis	Marion
Perrin, K. F.	Ft. Wayne	Allen
Perry, F. G.	Ft. Wayne	Allen
Peters, Elmer E.	Indianapolis	Marion
Peters, R. J. D.	Indianapolis	Marion
Peterson, Joel A.	Lafayette	Tippecanoe
Petitjean, H. G.	Haubstadt	Gibson
Petranoff, T. V.	Indianapolis	Marion
Petrass, Andrew	South Bend	St. Joseph
Petronella, S. J.	East Chicago	Lake
Pettibone, C. R.	East Lansing, Mich.	Lake
Pettijohn, F. L. (H)	Indianapolis	Marion
Petway, Allen P.	Madison	Jefferson
Peyton, Frank W.	Lafayette	Tippecanoe
Pfaff, John A. (H)	Indianapolis	Marion
Pfafflin, C. A. (H)	Indianapolis	Marion
Pfeifer, James M.	Lawrenceburg	Dearborn-Ohio
Phares, Robert W.	Kokomo	Howard
Phipps, Elwood B.	Clinton	Parke-Vermillion
Phipps, Leland K.	Union City	Randolph
Piazza, Leonard F.	Michigan City	LaPorte
Pickett, Robert D.	Indianapolis	Marion
Pierce, Gene Stratton	Wheatland	Knox
Pierce, H. J.	Terre Haute	Vigo
Pierce, Wm. J.	Indianapolis	Marion
Pierson, P. R.	New Albany	Floyd
Pierson, Robert H.	Crawfordsville	Montgomery
Pierson, Thomas A.	New Palestine	Hancock
Pike, Warren H.	Hobart	Lake
Pilcher, Jack	Indianapolis	Marion
Pilot, Jean	Hammond	Lake
Pippenger, W. G.	Brook	Jasper-Newton
Pirkle, H. B.	Rockville	Parke-Vermillion
Pitkin, Edward M.	Martinsville	Morgan
Pitkin, M. C.	Martinsville	Morgan
Plain, George	South Bend	St. Joseph
Plank, C. Robert	Michigan City	LaPorte
Ploughe, Monroe L. (H)	Elwood	Madison
Ploughe, R. R.	Elwood	Madison
Polhemus, Gretchen I.	New Albany	Floyd
Polhemus, Warren C.	Anderson	Madison
Pollak, Lewis	Indianapolis	Marion
Pollard, Walter	Evansville	Vanderburgh
Pollom, Robert	Crawfordsville	Montgomery
Pomeroy, Rex K.	Plymouth	Marshall
Poolitson, Geo. C.	Bloomington	Owen-Monroe
Popp, M. F.	Ft. Wayne	Allen
Porro, Francis W.	Evansville	Vanderburgh
Porter, Carl M.	Jasonville	Greene
Porter, E. A.	Westport	Decatur
Porter, George C.	Linton	Greene
Porter, Jack	Lebanon	Boone
Porter, John R.	Lebanon	Boone
Porter, M. F.	Ft. Wayne	Allen
Portteus, Walter L.	Franklin	Johnson
Possolt, T. R.	Elkhart	Elhart
Poston, C. L.	Bellwood, Ill.	Wayne-Union
Powell, H. M., Jr.	Indianapolis	Marion
Powell, J. Paxton	Marion	Grant
Powell, Nettie B. (H)	Marion	Grant
Premuda, F. E.	Hammond	Lake
Prenatt, Francis	Madison	Jefferson
Prentiss, Nelson M.	Ft. Wayne	Allen
Present, Julian	Evansville	Vanderburgh
Price, Douglas W.	Nappanee	Elkhart
Price, Ernest H.	Danville	Hendricks
Price, James O.	Indianapolis	Marion
Price, Melvin D. (H)	Nappanee	Elkhart
Price, W. A. (H)	Nappanee	Elkhart
Prosser, Wm. O. H.	Bloomington	Owen-Monroe
Proudfit, Charles H.	South Bend	St. Joseph
Province, O. A.	Franklin	Johnson
Province, William D.	Franklin	Johnson
Pruitt, J. Edward	Dunkirk	Delaware-Blackford
Pryor, R. C.	Indianapolis	Marion
Przednowek, A. C.	LaPorte	LaPorte
Pugh, Willis L.	Evansville	Vanderburgh
Pulskamp, B. H.	Wolcottville	Noble
Puterbaugh, K. E.	Albany	Delaware-Blackford
Pyle, Harold D.	South Bend	St. Joseph

Q

Name	City	County
Quick, Wm. J.	Muncie	Delaware-Blackford
Quickel, Daniel S. (H)	Anderson	Madison
Quigley, Joseph B.	Indianapolis	Marion

R

Name	City	County
Rabb, Frank M.	Indianapolis	Marion
Rabb, Harry	Indianapolis	Marion
Raber, Robert M.	Indianapolis	Marion
Rabson, S. Milton	Ft. Wayne	Allen
Radding, Robert S.	Indianapolis	Marion
Rader, George S.	Indianapolis	Marion
Radigan, Leo R.	Indianapolis	Lake
Ragsdale, H. C.	Bedford	Lawrence
Rainey, E. A.	Lebanon	Boone
Ramage, W. F.	Beech Grove	Marion
Ramey, John W.	Kokomo	Howard
Ramker, Daniel T.	East Chicago	Lake
Ramsey, Frank B.	Indianapolis	Marion
Ramsey, H. S.	Bloomington	Owen-Monroe
Ranes, J. R.	Mt. Vernon	Posey
Raney, B. B.	Linton	Greene
Rang, A. A.	Washington	Daviess-Martin
Rang, Robert H.	Washington	Daviess-Martin
Ranke, John W. H. (H)	Ft. Wayne	Allen
Raper, George T.	Freelandville	Knox
Raphael, Isidor J.	Evansville	Vanderburgh
Rariden, L. B.	Greenfield	Hancock
Rasmussen, Ruth F.	South Bend	St. Joseph
Ratcliff, A. L. (H)	Kingman	Fountain-Warren
Ratcliff, Frank W.	Lafayette	Tippecanoe
Ratcliffe, A. W.	Evansville	Vanderburgh
Rausch, Norman W.	Angola	Steuben
Rauschenbach, C. W.	Hammond	Lake
Ravdin, Bernard	Evansville	Vanderburgh
Ravdin, Marcus (H)	Evansville	Vanderburgh
Rawles, Lyman T.	Ft. Wayne	Allen

Name	City	County
Rawlins, Carolyn M.	Hammond	Lake
Rayl, C. C.	Decatur	Adams
Reck, J. L.	Sheridan	Hamilton
Records, A. W.	Franklin	Johnson
Reed, Ann	Michigan City	LaPorte
Reed, J. V.	Indianapolis	Marion
Reed, John J.	Hobart	Lake
Reed, Nelle C.	Michigan City	LaPorte
Reed, Philip B.	Indianapolis	Marion
Reed, Robert C.	Terre Haute	Vigo
Reed, R. R.	Anderson	Marion
Reed, Wm. C.	Bloomington	Owen-Monroe
Rees, Russell C.	Indianapolis	Marion
Regan, George L.	Sellersburg	Clark
Reich, Clarence E.	Evansville	Vanderburgh
Reid, Chas. A.	Indianapolis	Marion
Reid, Robert W.	Union City	Randolph
Reilly, James F.	Vincennes	Knox
Reisler, Simon	Indianapolis	Marion
Reitz, Thomas F.	Evansville	Vanderburgh
Remich, A. C.	Hammond	Lake
Renbarger, L. L.	Marion	Grant
Rendel, D. T.	Hammond	Lake
Rendel, H. E.	Mexico	Miami
Reppert, Roland L.	Decatur	Adams
Rettig, A. C.	Muncie	Delaware-Blackford
Reusser, Amos (H)	Berne	Adams
Reynolds, D. M.	Garrett	DeKalb
Reynolds, J. S.	Gary	Lake
Reynolds, R. P.	Garrett	DeKalb
Reynolds, Richard J.	Terre Haute	Vigo
Rhamy, A. P.	Wabash	Wabash
Rhea, G. D.	Greencastle	Putnam
Rhea, James C.	Beech Grove	Marion
Rhind, A. W.	Hammond	Lake
Rhodes, A. H.	Princeton	Gibson
Rhodes, Theodore D.	Indianapolis	Marion
Rhorer, H. M.	Kokomo	Howard
Rhorer, John G.	Marion	Grant
Rice, Raymond M.	Indianapolis	Marion
Rice, Thurman B.	Indianapolis	Marion
Rice, T. R. (H)	Petersburg	Pike
Rice, W. B.	Ft. Wayne	Allen
Richard, Norman F.	Shelbyville	Shelby
Richards, D. H. (H)	Vincennes	Knox
Richards, E. E.	Russellville	Montgomery
Richardson, C. L.	Rochester	Fulton
Richardson, Thad T.	Indianapolis	Marion
Richart, J. V.	Terre Haute	Vigo
Richer, O. H.	Warsaw	Kosciusko
Richter, Arthur B.	Indianapolis	Marion
Richter, John C.	LaPorte	LaPorte
Richter, Samuel	Gary	Lake
Ricketts, J. W.	Indianapolis	Marion
Ridgeway, O. W.	Indianapolis	Marion
Ridgway, Alton H.	Belgian Congo, Africa	Marion
Rifner, E. S.	Van Buren	Grant
Rigg, J. F.	Indianapolis	Marion
Riggs, Floyd	Terre Haute	Vigo
Rigley, E. L.	South Bend	St. Joseph
Riley, Frank	Jamestown	Boone
Rininger, Harold C.	Evansville	Vanderburgh
Rinne, John I.	Lapel	Madison
Ripley, John W.	Seymour	Jackson
Rissing, Walter J.	Ft. Wayne	Allen
Richter, John C.	LaPorte	LaPorte
Ritchey, J. O.	Indianapolis	Marion
Ritchie, John W.	Santa Barbara Calif.	Delaware-Blackford
Ritteman, George W.	Columbus	Bartholomew-Brown
Ritter, Wayne L.	Indianapolis	Marion
Ritz, Albert S.	Evansville	Vanderburgh

Name	City	County
Rivers, Glynn A.	Muncie	Delaware-Blackford
Robb, John A.	Indianapolis	Marion
Robertson, A. N.	New Albany	Floyd
Robertson, D. W. (H)	Deputy	Jennings
Robertson, James S.	Plymouth	Marshall
Robertson, M. O.	Bedford	Lawrence
Robertson, Ray	Indianapolis	Marion
Robertson, W. C.	Shipshewana	LaGrange
Robinson, Earl U.	Evansville	Vanderburgh
Robinson, Walter K.	Gary	Lake
Robison, C. A.	Frankfort	Clinton
Robison, J. S.	Winchester	Randolph
Robrock, Lawrence M.	Michigan City	LaPorte
Rockey, Noah A.	Ft. Wayne	Allen
Rodenbeck, Frank	Arcadia	Hamilton
Rodin, Herman H.	South Bend	St. Joseph
Rodriguez, Juan	Ft. Wayne	Allen
Roesch, Ryland	Kentland	Knox
Rogers, Evered E.	Auburn	DeKalb
Rogers, O. F.	Bloomington	Owen-Monroe
Rogers, R. C. (H)	Bloomington	Owen-Monroe
Rogers, Thomas P.	Bethesda, Md.	Marion
Rohr, Joseph H.	Elkhart	Elkhart
Rohrer, J. R.	Elnora	Daviess-Martin
Roll, E. C.	Seattle, Wash.	Marion
Roller, C. W.	Indianapolis	Marion
Rollins, Russell	Royal Center	Cass
Romberger, Floyd T.	Lafayette	Tippecanoe
Romberger, Floyd T., Jr.	Indianapolis	Marion
Rommel, Clarence H.	W. Lafayette	Tippecanoe
Ropp, H. E.	New Harmony	Posey
Rose, Bertha	W. Lafayette	Tippecanoe
Rose, Stuart W.	Montreal, Can.	Delaware-Blackford
Rosenak, Bernard D.	Indianapolis	Marion
Rosenbaum, David	Indianapolis	Marion
Rosenbaum, Irving, Jr.	Indianapolis	Marion
Rosenbaum, L. E.	Anderson	Madison
Rosenblatt, B. B.	Evansville	Vanderburgh
Rosenbloom, P. J.	Gary	Lake
Rosenfeld, Norman B.	Clinton	Parke-Vermillion
Rosenheimer, Geo. M.	South Bend	St. Joseph
Rosenwasser, Jacob	Mishawaka	St. Joseph
Roser, A. J.	Ft. Wayne	Allen
Rosevear, Henry J.	Hammond	Lake
Ross, Alexander T.	Indianapolis	Marion
Ross, Ben R.	Bloomington	Owen-Monroe
Ross, Guy E.	Anderson	Madison
Ross, Harry P.	Richmond	Wayne-Union
Ross, James S.	Richmond	Wayne-Union
Ross, Louis F.	Richmond	Wayne-Union
Ross, W. W.	La Porte	La Porte
Rossiter, D. L.	Ft. Wayne	Allen
Rossow, Russell J.	Evansville	Vanderburgh
Roth, Bertram	St. Louis, Mo.	Delaware-Blackford
Roth, James	Wolf Lake	Noble
Rothberg, Maurice J.	Ft. Wayne	Allen
Rothenberger, Daniel J.	Indianapolis	Marion
Rothring, Howard E.	Indianapolis	Marion
Rothrock, Philip W.	Lafayette	Tippecanoe
Rothschild, C. J.	Ft. Wayne	Allen
Rotman, Harry G.	Jasonville	Greene
Rotman, Sam I.	Jasonville	Greene
Row, D. Hamilton	Indianapolis	Marion
Row, George S.	Osgood	Ripley
Row, Perrie Q.	Hammond	Lake
Rowdabaugh, Marshall J.	South Bend	South Bend
Rowe, Howard H.	Rochester	Fulton
Royster, Robert A.	Evansville	Vanderburgh
Rozelle ,Clarence V.	Anderson	Madison
Rubens, Eli	South Bend	St. Joseph
Rubin, Gerald S.	Indianapolis	Marion

Name	City	County
Rubin, M. R.	Gary	Lake
Rubin, Milton M.	Terre Haute	Vigo
Rubin, Simon S.	Gary	Lake
Ruby, Fred McKemy	Union City	Randolph
Ruddell, Karl R.	Indianapolis	Marion
Ruddell, Keith R.	Indianapolis	Marion
Ruddick, H. C.	Evansville	Vanderburgh
Rudesill, C. L.	Indianapolis	Marion
Rudesill, Robert	Indianapolis	Marion
Rudicel, Max	South Bend	St. Joseph
Rudolph, Carl J.	South Bend	St. Joseph
Rudolph, F. G.	Hammond	Lake
Rudolph, Stephen, Jr.	Indianapolis	Marion
Rudser, D. H.	Whiting	Lake
Runge, Paul W.	Richmond	Wayne-Union
Rupel, Ernest	Indianapolis	Marion
Rusche, Henry J.	Evansville	Vanderburgh
Ruschli, E. B.	Lafayette	Tippecanoe
Rusk, Hubert M.	Wallace	Fountain-Warren
Russell, Richard H.	Evansville	Vanderburgh
Rust, Byron K.	Indianapolis	Marion
Ruth, Martin L.	Indianapolis	Marion
Rutherford, C. W.	Indianapolis	Marion
Ryan, Glen V.	Indianapolis	Marion
Ryan, H. J.	Gary	Lake
Ryan, William J.	Columbus	Bartholomew-Brown
Ryan, William J. J.	Ft. Wayne	Allen

S

Name	City	County
Sage, Charles V., Jr.	Richmond	Wayne-Union
Sage, Russell	Indianapolis	Marion
Sagel, Jacob	Gary	Lake
Sahlman, Hans	Ft. Wayne	Allen
Saide, Robert A.	W. Los Angeles, Cal.	La Porte
Sala, J. J.	Gary	Lake
Sala, Walter R.	Gary	Lake
Salb, Leo A.	Jasper	Dubois
Salb, Max C.	Indianapolis	Marion
Salkin, Irwin	Indianapolis	Marion
Sallee, William T.	Indianapolis	Marion
Salon, Harry W.	Ft. Wayne	Allen
Salon, N. L.	Ft. Wayne	Allen
Salzman, Morris	Indianapolis	Marion
Samples, J. T.	Boonville	Warrick
Sanders, Harry M.	Indianapolis	Marion
Sanders, J. A.	Auburn	De Kalb
Sanderson, R. B.	South Bend	St. Joseph
Sandock, Isadore	South Bend	St. Joseph
Sandock, Louis	South Bend	St. Joseph
Sandorf, M. H.	Indianapolis	Marion
Sandoz, Harry	South Bend	St. Joseph
Sandoz, Louis A.	South Bend	St. Joseph
Sandy, Wm. A.	Marion	Grant
Saunders, J. L.	Newport	Parke-Vermillion
Savage, A. R.	Ft. Wayne	Allen
Savery, C. E.	South Bend	St. Joseph
Sayers, F. E.	Terre Haute	Vigo
Scamahorn, Malcolm O.	Pittsboro	Hendricks
Scamahorn, O. T.	Pittsboro	Hendricks
Schaaf, Alvin	Jamestown	Boone
Schaefer, C. R. (H)	Indianapolis	Marion
Schafer, Donald W.	Ft. Wayne	Allen
Schafer, William C.	Washington	Daviess-Martin
Schaible, E. L.	Gary	Lake
Schantz, Richard	Remington	Jasper-Newton
Schauwecker, Cleon M.	Greencastle	Putnam
Schechter, John S.	Indianapolis	Marion
Schecter, William J.	Los Angeles, Cal.	Marion
Scheetz, Marion R.	Lewisville	Henry
Scheier ,E. W.	Indianapolis	Marion
Schell, Harry D.	Bloomington	Owen-Monroe
Schellhouse, Earl	Fort Wayne	Allen
Schenck, Foss	Logansport	Cass
Schenk, G. H.	Ridgeville	Randolph
Scherb, Burton E.	Terre Haute	Vigo
Scherschel, John P.	Bedford	Lawrence
Schetgen, Joseph V.	Geneva	Adams
Scheurich, Virgil	Oxford	Benton
Schick, Martin F. (H)	Ft. Wayne	Allen
Schiller, Herbert A.	South Bend	St. Joseph
Schirmer, Robert H.	Evansville	Vanderburgh
Schlademan, Karl R.	Ft. Wayne	Allen
Schlagel, T. F., Jr.	Indianapolis	Marion
Schlegel, Edward H.	Ft. Wayne	Allen
Schlemmer, George H.	Warsaw	Kosciusko
Schlesinger, Daniel	Hammond	Lake
Schlesinger, Jacob	Hammond	Lake
Schlieker, A. G. (H)	Spencer	Lake
Schlosser, H. C.	Elkhart	Elkhart
Schmidt, Loren F.	Indianapolis	Marion
Schmidt, Richard H.	Indianapolis	Marion
Schmiedicke, P. H.	Williamsport	Fountain-Warren
Schmitt, Richard K.	Columbus	Bartholomew-Brown
Schmoll, Robert J.	Ft. Wayne	Allen
Schneider, Carl J.	Indianapolis	Marion
Schneider, C. P.	Evansville	Vanderburgh
Schneider, Kenneth	Nashville	Bartholomew-Brown
Schneider, Louis A.	Ft .Wayne	Allen
Schoen, Frederic L.	Ft. Wayne	Allen
Schoolfield, Wm. E.	Orleans	Orange
Schott, Edward J.	Terre Haute	Vigo
Schreiner, John E.	Bremen	Marshall
Schriefer, Victor V.	Evansville	Vanderburgh
Schroeder, Henry	Washington	Marion
Schuchman, Gabriel	Indianapolis	Marion
Schuldt, T. S.	Pierceton	Kosciusko
Schuler, R. P.	Kokomo	Howard
Schulhof, M. G.	Muncie	Delaware-Blackford
Schulz, C. H.	LaGrange	LaGrange
Schulze, Wm.	Vincennes	Knox
Schumaker, Robert A.	Terre Haute	Vigo
Schuman, Edith B.	Bloomington	Owen-Monroe
Schuster, Dwight W.	Indianapolis	Marion
Schutt, J. B.	Ligonier	Noble
Schwartz, Fred C.	Kokomo	Howard
Schwartz, W. D. (H)	Portland	Jay
Schweitzer, Ada E. (H)	Indianapolis	Marion
Scoins, W. H.	Ft. Wayne	Allen
Scott, Charles C.	Shelbyville	Shelby
Scott, Frank M.	South Bend	St. Joseph
Scott, G. D.	Sullivan	Sullivan
Scott, George E.	Indianapolis	Delaware-Blackford
Scott, H. V.	Ft. Wayne	Allen
Scott, Irvin H.	Sullivan	Sullivan
Scott, I. W.	Indianapolis	Marion
Scott, John S.	Indianapolis	Marion
Scott, R. F.	Kokomo	Howard
Scott, Robert P.	Indianapolis	Marion
Scott, S. L.	Indianapolis	Marion
Scott, V. Brown	Shelbyville	Shelby
Scudder, A. N.	Brownsburg	Hendricks
Scudder, J. A.	Edwardsport	Knox
Seal, Perry F.	Brookville	Fayette-Franklin
Seale, Joseph P.	Fairmount	Grant
Seaman, C. F.	Indianapolis	Marion
Sears, M. Maywood	Elkhart	Elkhart
Seaton, Albert	Indianapolis	Marion
Sedam, Herbert L.	Indianapolis	Marion
Segar, Louis H.	Indianapolis	Marion

Name	City	County
Seibel, Robert M.	Morgantown	Morgan
Seitz, P. F. D.	Indianapolis	Marion
Selby, K. E.	South Bend	St. Joseph
Selsam, Etta B.	Terre Haute	Vigo
Senese, T. J.	Gary	Lake
Sennett, C. M.	South Bend	St. Joseph
Sennett, Wm. K.	Macy	Miami
Sensenich, R. L.	South Bend	St. Joseph
Senseny, Herbert	Ft. Wayne	Allen
Seward, G. W.	N. Manchester	Wabash
Sexson, Hiram	Indianapolis	Marion
Seybert, J. D.	Kendallville	Noble
Seyler, Anna G.	Crown Point	Lake
Shacklett, Henry B. (H)	New Albany	Floyd
Shafer, J. W.	Lafayette	Tippecanoe
Shafer, Marion R.	Indianapolis	Marion
Shafer, Richard H.	Alexandria	Madison
Shaffer, K. L.	Vincennes	Knox
Shallenberger, H. R.	Modoc	Randolph
Shanklin, E. M.	Hammond	Lake
Shanklin, V. A.	Terre Haute	Vigo
Shanks, Ray W.	Noblesville	Hamilton
Shanks, Roy E.	Rushville	Rush
Shapiro, Joseph	East Chicago	Lake
Sharman, Edward J.	Louisville, Ky.	Jefferson
Sharp, John L.	Crawfordsville	Montgomery
Sharp, W. L.	Anderson	Madison
Shattuck, John C.	Brazil	Clay
Sheehan, Francis G.	Indianapolis	Marion
Sheek, Kenneth I.	Greenwood	Johnson
Sheller, Thomas G.	Argos	Marshall
Shelley, Edward	South Bend	St. Joseph
Shellhouse, Michael	Gary	Lake
Shenk, E. M.	Kokomo	Howard
Shepard, Fred F.	College Corner, Ohio	Wayne-Union
Sheridan, Joseph L.	Wash., D. C.	Marion
Sherman, Robert M.	Cincinnati, O.	Wells
Sherster, Harry	Indianapolis	Marion
Shields, Harry A.	Washington	Daviess-Martin
Shields, Jack E.	Brownstown	Marion
Shields, Tom S.	Richmond	Wayne-Union
Shinabery, Lawerence	Ft. Wayne	Allen
Shively, John A.	Bluffton	Wells
Shively, John L.	Hagerstown	Henry
Sholty, W. M.	Lafayette	Tippecanoe
Shonk, Harold W.	Noblesville	Hamilton
Short, John	Ft. Wayne	Allen
Shortridge, W. H.	Seymour	Jackson
Shoup, H. B.	Greentown	Howard
Showalter, John P.	Waterloo	De Kalb
Showalter, John R.	Terre Haute	Vigo
Shrigley, Edw. W.	Indianapolis	Marion
Shrock, E. E.	Amboy	Miami
Shuck, Wm. A.	Madison	Jefferson
Shugart, Joseph D.	Indianapolis	Marion
Shullenberger, W. A.	Indianapolis	Marion
Shulruff, H. I.	East Chicago	Lake
Shultz, H. M.	Logansport	Cass
Shumacker, H. B., Jr.	Indianapolis	Marion
Sibbitt, Joseph	Bellwood, Ill.	Clinton
Sicks, O. W.	Indianapolis	Marion
Sidebottom, Earl	Indianapolis	Marion
Siebenmorgen, Louis	Terre Haute	Vigo
Siebenmorgen, Paul	Terre Haute	Vigo
Siegman, Edw. L.	Terre Haute	Vigo
Siekerman, C. W.	Indianapolis	Marion
Siekierski, J. M.	Griffith	Lake
Siersdorfer, T. N.	Indianapolis	Marion
Sigmond, Harvey W.	Indianapolis	Marion
Sigmund, Wm. B.	Columbus	Bartholomew-Brown
Silbert, David	Shelbyville	Shelby
Silverman, Norman M.	Terre Haute	Vigo
Silvers, J. M.	Muncie	Delaware-Blackford
Silvian, Harry	Whiting	Lake
Simmons, Frederick H.	Marion	Grant
Simmons, L. H.	Goshen	Elkhart
Simms, J. Leon	Indianapolis	Marion
Simon, A. R.	La Porte	La Porte
Simons, James (H)	Lyons	Greene
Simpson, Wm. D.	Indianapolis	Marion
Sims, J. Lawrence	Indianapolis	Marion
Singer, E. C.	Ft. Wayne	Allen
Sink, Frank G.	Remington	Jasper-Newton
Sirlin, E. M.	Mishawaka	St. Joseph
Sisson, Helen M.	Pendleton	Madison
Skeen, E. D.	Gary	Lake
Skillern, P. G.	South Bend	St. Joseph
Skomp, Claud E.	Marion	Grant
Slabaugh, J. S.	Nappanee	Elkhart
Slama, George	Gary	Lake
Slaughter, Howard C.	Evansville	Vanderburgh
Slaughter, John	Evansville	Vanderburgh
Slaughter, Owen L.	Evansville	Vanderburgh
Slick, C. R.	Lynn	Randolph
Sloan, H. P.	New Albany	Floyd
Slocum, Yudell K.	Indianapolis	Marion
Slominski, H. H.	South Bend	St. Joseph
Sloss, I. H.	Terre Haute	Vigo
Sluss, David H.	Indianapolis	Marion
Sluss, John W. (H)	Indianapolis	Marion
Smallwood, R. B.	Bedford	Lawrence
Smelser, H. W.	Connersville	Fayette-Franklin
Smiley, J. H.	Indianapolis	Marion
Smith, B. J.	Kingman	Fountain-Warren
Smith, Charles G.	Otterbein	Benton
Smith, David J.	Indianapolis	Marion
Smith, D. L.	Indianapolis	Marion
Smith, E. Rogers	Indianapolis	Marion
Smith, Francis C.	Indianapolis	Marion
Smith, Frederick R.	Spencer	Owen-Monroe
Smith, G. A.	New Haven	Allen
Smith, Gloster J.	Kokomo	Howard
Smith, H. N.	Brookville	Fayette-Franklin
Smith, H. S.	Bloomington	Owen-Monroe
Smith, James M.	Indianapolis	Marion
Smith, James S.	Muncie	Delaware-Blackford
Smith, L. C.	Lafayette	Tippecanoe
Smith, L. W.	Warren	Huntington
Smith, Lester A.	Indianapolis	Marion
Smith, Marsh H.	Goodland	Jasper-Newton
Smith, Paul E.	Ellettsville	Owen-Monroe
Smith, Ralph O.	Vincennes	Knox
Smith, Robert A.	New Castle	Henry
Smith, R. D. (H)	Bloomington	Owen-Monroe
Smith, R. Lee	Osgood	Ripley
Smith, Richard B.	New Haven	Allen
Smith, Roger C.	New Haven	Allen
Smith, Roy L.	Indianapolis	Marion
Smith, S. Joseph	Vincennes	Knox
Smith, T. J.	Whiting	Lake
Smith, W. E. (H)	Decatur	Adams
Smith, Wilbur F.	Indianapolis	Marion
Smith, William B.	Indianapolis	Marion
Smoot, Emory B.	Washington	Daviess-Martin
Smoots, S. A.	Terre Haute	Vigo
Sneary, K. D.	Avilla	Noble
Snider, Byron	Indianapolis	Marion
Snively, W. D., Jr.	Evansville	Vanderburgh
Snyder, E. R.	Troy	Perry
Snyder, Morris C.	Richmond	Wayne-Union
Solomon, R. A.	Indianapolis	Marion
Somers, G. H.	Ft. Wayne	Allen
Sorenson, Raymond	Kokomo	Howard

Name	City	County
Sosson, Edward	Hammond	Lake
Souder, Bonnell M.	Auburn	De Kalb
Sourwine, C. C.	Brazil	Clay
Souter, Martha C.	Indianapolis	Marion
Southard, C. B.	Noblesville	Hamilton
Sovine, Joe W.	Indianapolis	Marion
Spahr, D. E.	Portland	Jay
Spahr, John F.	Indianapolis	Marion
Spalding, J. J.	Indianapolis	Marion
Spalding, W. L.	Mishawaka	St. Joseph
Spangler, Jesse S.	Kokomo	Howard
Sparks, A. Jerome	Ft. Wayne	Allen
Sparks, Alan L.	Indianapolis	Marion
Sparks, Paul W.	Winchester	Randolph
Spears, John K.	Paoli	Orange
Speas, Robert C.	Terre Haute	Vigo
Speheger, Benjamin A.	Bedford	Lawrence
Spellman, Frank A.	Gary	Lake
Spencer, Beaufort A.	Bloomington	Owen-Monroe
Spencer, Frederic	Vincennes	Knox
Spenner, R. W.	South Bend	St. Joseph
Spieth, Wm. H.	Lebanon	Boone
Spigler, James	Terre Haute	Vigo
Spindler, Robert D.	Shelbyville	Shelby
Spink, Urbana	Indianapolis	Marion
Spinning ,Alva (H)	Michigan City	Fountain-Warren
Spivey, R. J.	Indianapolis	Marion
Spolyar, L. W.	Indianapolis	Marion
Spray, Page E.	Elkhart	Elkhart
Springstun, C. E.	Tennyson	Warrick
Springstun, C. L.	Chrisney	Spencer
Springstun, George	Oaktown	Knox
Springstun, W. R.	Evansville	Vanderburgh
Spurgeon, O. E.	Muncie	Delaware-Blackford
Spurlock, Fae	W. Lafayette	Tippecanoe
Sputh, Carl B., Sr.	Indianapolis	Marion
Sputh, Carl B., Jr.	Indianapolis	Marion
Sroka, Stanley J.	Highland (Hammond)	Lake
Stadler, Harold E.	Indianapolis	Marion
Staff, Robert A.	Rockville	Parke-Vermillion
Stafford, J. C.	Plainfield	Hendricks
Stafford, W. C.	Plainfield	Hendricks
Stahl, Edward	Lafayette	Tippecanoe
Stalker, John M.	Borden	Clark
Stamper, J. H.	Anderson	Madison
Stamper, L. Allen	Richmond	Wayne-Union
Stangle, W. J.	Bloomington	Owen-Monroe
Stanley, J. S.	Indianapolis	Marion
Stanton, J. J.	Logansport	Cass
Stauffer, George E.	Mooreland	Henry
Stauffer, Richard C.	Ft. Wayne	Allen
Stauffer, Walter A.	Elkhart	Elkhart
Staunton, Henry A.	South Bend	St. Joseph
Stayton, C. A.	Indianapolis	Marion
Stayton, Chester A., Jr.	Indianapolis	Marion
Stecy, Peter	Whiting	Lake
Steele, Dick J.	Greencastle	Putnam
Steele, E. B.	Crown Point	Lake
Steele, Paul W.	Evansville	Vanderburgh
Steffen, A. J.	Wabash	Wabash
Steffen, J. T.	Wabash	Wabash
Steffy, Ralph M.	Indianapolis	Marion
Steinkamp, E. F.	Huntingburg	Dubois
Steinman, H. E.	Monroeville	Allen
Stellner, Howard A.	Ft. Wayne	Allen
Stemm, W. H. (H)	North Vernon	Jennings
Stephens, Donald E.	Indianapolis	Marion
Stephens, K. H.	Indianapolis	Marion
Stephens, Lowell R.	Covington	Fountain-Warren
Stephens, R. Clarence (H)	Plymouth	Marshall
Stepleton, John D.	Richmond	Wayne-Union
Stern, Nathan	Indianapolis	Marion
Stern, S. L.	Hammond	Lake
Sterne, John H.	Evansville	Vanderburgh
Stevens, S. L.	Indianapolis	Marion
Stewart, Milton B. (H)	Logansport	Cass
Stewart, O. H.	Aurora	Dearborn-Ohio
Stewart, W. E.	Terre Haute	Vigo
Stier, Paul L.	Ft. Wayne	Allen
Stimson, H. R.	Gary	Lake
Stine, Marshall E.	Bremen	Marshall
Stinson, A. E.	Rochester	Fulton
Stinson, Dean K.	Rochester	Fulton
Stiver, Daniel	South Bend	St. Joseph
Stocking, B. W.	Muncie	Delaware-Blackford
Stoelting, J. Lewis	Terre Haute	Vigo
Stoelting, V. K.	Indianapolis	Marion
Stoler, A. E.	Ft. Wayne	Allen
Stone, A. T.	Indianapolis	Marion
Stone, David F.	Indianapolis	Marion
Stoops, Jean T.	Wabash	Wabash
Storer, Wm. R.	Hobart	Lake
Storey, D. E.	Indianapolis	Marion
Storey, Joseph L.	Indianapolis	Marion
Stork, Harvey K.	Huntingburg	Dubois
Stork, Urban	Evansville	Vanderburgh
Storms, Roy B.	Indianapolis	Marion
Stouder, Albert E.	Kempton	Tipton
Stout, Francis E.	Indianapolis	Marion
Stout, Harry T.	Frankfort	Clinton
Stout, R. B.	Elkhart	Elkhart
Stout, Walter M.	New Castle	Henry
Stover, Wendell C.	Boonville	Warrick
Stoycoff, C. M.	Gary	Lake
Strange, Dempsey C.	Indianapolis	Marion
Strange, J. W.	Loogootee	Daviess-Martin
Stratigos, Jos. S.	South Bend	St. Joseph
Straus, David C.	Michigan City	La Porte
Strayer, J. W.	Lafayette	Tippecanoe
Streck, F. A.	Lawrenceburg	Dearborn-Ohio
Strecker, Wm. L.	Terre Haute	Vigo
Streepey, J. I.	New Albany	Floyd
Streib, Homer F.	Chula Vista, Calif.	Jay
Strickland, Karl S.	Princeton	Gibson
Strickland, Martha B.	Lafayette	Tippecanoe
Strickland, Wm. B.	Mitchell	Lawrence
Strong, Daniel S.	Terre Haute	Vigo
Stroup, Tyler J.	Indianapolis	Marion
Stubbins, William M.	Elkhart	Elkhart
Stuckman, E. N. (H)	New Paris	Elkhart
Stucky, Ellsworth	Indianapolis	Marion
Stultz, Q. F.	Ligonier	Noble
Stump, Thomas A.	Indianapolis	Marion
Sturgis, Donald G.	Sellersburg	Clark
Stygall, James H.	Indianapolis	Marion
Sudranski, Herbert F.	Indianapolis	Marion
Sugarman, Benj. E.	French Lick	Orange
Sullenger, A. A.	Marion	Grant
Sullivan, John M.	Terre Haute	Vigo
Sutter, Charles C.	Evansville	Vanderburgh
Sutton, Wm. E.	Indianapolis	Marion
Suzuki, Tsutomu T.	Covington	Fountain-Warren
Swan, John R.	Indianapolis	Marion
Swan, Richard Carl	Anderson	Madison
Swank, L. Forrest	Elkhart	Elkhart
Swayne, J. F.	Indianapolis	Marion
Sweet, Howard E.	Richmond	Wayne-Union
Swihart, Homer R.	Elkhart	Elkhart
Swihart, L. F.	Elkhart	Elkhart
Switzer, Robert E.	Denver, Colorado	Noble

Name	City	County
Symmes, Alfred T.	Indianapolis	Marion
Szynal, John S.	Indianapolis	Marion

T

Name	City	County
Take, J. F. (H)	French Lick	Orange
Talbert, Pierre C.	Bluffton	Wells
Talbott, Dan E.	Indianapolis	Marion
Tanner, Henry S.	Indianapolis	Marion
Taylor, C. C.	Indianapolis	Marion
Taylor, E. C.	Upland	Grant
Taylor, Eugene C.	Evansville	Vanderburgh
Taylor, F. W.	Indianapolis	Marion
Taylor, James A. (H)	Montpelier	Delaware-Blackford
Taylor, W. H.	Ambia	Benton
Taylor, W. R.	Richmond	Wayne-Union
Teaford, S. F.	Paoli	Orange
Teague, Frank	Indianapolis	Marion
Teal, Dorothy D.	Columbus	Bartholomew-Brown
Teegarden, J. A., Jr.	East Chicago	Lake
Teegarden, J. A., Sr.	East Chicago	Lake
Teixler, V. A.	Indianapolis	Marion
Templeton, Ames R.	Mishawaka	St. Joseph
Templin, D. B.	Gary	Lake
Tennant, David L.	Ft. Wayne	Allen
Tennant, L. W. (H)	Ft. Wayne	Whitley
Tennis, George	Greencastle	Putnam
Teplinsky, L. Louis	Munster	Lake
Terflinger, F. W. (H)	Logansport	Cass
Terrill, R. W.	Ft. Wayne	Allen
Terry, Lloyd	Danville	Hendricks
Terry, William B. G., Jr.	Indianapolis	Marion
Terveer, John B.	Decatur	Adams
Test, Charles E.	Chicago	Marion
Teter, Geo. V., Jr.	San Francisco, Calif.	Marion
Teters, Melvin S.	Middlebury	Elkhart
Tether, Joseph E., Jr.	Indianapolis	Marion
Tharpe, Ray	Indianapolis	Marion
Thatcher, H. K., Jr.	Indianapolis	Marion
Thayer, B. W.	North Vernon	Jennings
Thayer, J. O.	Noblesville	Marion
Thegze, George	Whiting	Lake
Thill, Leonard J.	Ashley	De Kalb
Thimlar, J. W.	Ft. Wayne	Allen
Thom, Jay W.	Indianapolis	Marion
Thom, Julia S.	Indianapolis	Marion
Thomas, C. E. (H)	Leesburg	Kosciusko
Thomas, Edward P.	Indianapolis	Marion
Thomas, Everett W.	Warsaw	Kosciusko
Thomas, G. A.	Lafayette	Tippecanoe
Thomas, Lowell I.	Indianapolis	Marion
Thomas, Morris E.	Indianapolis	Marion
Thompson, A. A.	Tyner	Marshall
Thompson, Chas. F.	Indianapolis	Marion
Thompson, Frank	Columbia City	Whitley
Thompson, Holland	Ft. Wayne	Allen
Thompson, John M.	South Bend	St. Joseph
Thompson, J. V.	Indianapolis	Marion
Thompson, Lewis	New Harmony	Posey
Thompson, Paul D.	Indianapolis	Marion
Thompson, Robert A.	South Bend	St. Joseph
Thompson, W. A.	Liberty	Wayne-Union
Thompson, Wm. R.	Winamac	Pulaski
Thornburg, Kenneth	Indianapolis	Marion
Thorne, C. E.	New Castle	Henry
Thornton, Harold C.	Indianapolis	Marion
Thornton, Maurice J.	South Bend	St. Joseph
Thornton, Walter E.	Ft. Wayne	Allen
Thrasher, John R.	Indianapolis	Marion
Thurston, H. S.	Indianapolis	Marion
Tilden, Margaret	Evansville	Vanderburgh
Tiley, George	Greenwood	Johnson
Tilka, Edward	Hammond	Lake
Tindal, E. F. (H)	Muncie	Delaware-Blackford
Tindall, Paul R.	Shelbyville	Shelby
Tindall, Wm. R.	Shelbyville	Shelby
Tinney, W. E.	Indianapolis	Marion
Tinsley, Frank W.	Indianapolis	Marion
Tinsley, W. B.	Indianapolis	Marion
Tipton, Wm. R.	Greencastle	Putnam
Tirman, Wallace S.	Bluffton	Wells
Tischer, E. Paul	Indianapolis	Marion
Titus, Charles (H)	Wilkinson	Hancock
Tomlin, Hugh M.	Muncie	Delaware-
Tomlinson, C. H. (H)	Lake Forest, Ill.	Hamilton
Topolgus, James N.	Bloomington	Owen-Monroe
Topping, M. C.	Terre Haute	Vigo
Torella, J. A.	Indianapolis	Marion
Toumey, Fred L.	Indianapolis	Marion
Tower, Thomas K.	Campbellsburg	Washington
Tranter, W. F.	Sharpsville	Tipton
Traver, P. C.	South Bend	St. Joseph
Travis, J. C., Jr.	Indianapolis	Marion
Tremain, M. A.	Adams	Decatur
Treon, James F.	Aurora	Dearborn-Ohio
Trepagnier, Francis B.	East Chicago	Lake
Trinosky, Donald L.	Gary	Lake
Tripp, H. D.	Plymouth	Marshall
Trout, C. J.	Lafayette	Tippecanoe
Troy, Jack M.	Whiting	Lake
Truman, Elmer M., Jr.	Rushville	Marion
Trusler, H. M.	Indianapolis	Marion
Tubbs, George R.	Lafayette	Tippecanoe
Tuchman, Joseph H.	Indianapolis	Marion
Tucker, O. A.	Daleville	Delaware-Blackford
Tucker, Robert L.	Indianapolis	Marion
Tucker, Warren S.	Indianapolis	Marion
Tully, J. A.	New Castle	Henry
Turley, Verne L.	Fowler	Benton
Turner, Anna Goss	Madison	Jefferson
Turner, H. B.	Bloomfield	Greene
Turner, Jack J.	Bloomfield	Greene
Turner, Maurice A.	Oakland City	Gibson
Turner, Oscar A.	Madison	Jefferson
Turner, Robert	Muncie	Delaware-Blackford
Tweedall, D. C.	Evansville	Vanderburgh
Tweedall, D. G.	Evansville	Vanderburgh
Tyler, F. T.	New Albany	Floyd
Tyrrell, Thomas C.	Calumet City, Ill.	Lake

U

Name	City	County
Uhrich, John H.	Monroeville	Allen
Underwood, G. B.	Evansville	Vanderburgh
Urschel, Dan L.	Mentone	Kosciusko
Utterback, Arnold	Terre Haute	Vigo

V

Name	City	County
Vagner, Bernard	South Bend	St. Joseph
Vail, George A.	Lawrenceburg	Dearborn-Ohio
VanArsdall, C. R.	Terre Haute	Vigo
VanBokkelen, Robert	Mooresville	Morgan
Van Buskirk, E. L.	Lafayette	Tippecanoe
Vance, Wm. C.	Richmond	Wayne-Union
VanderBogart, H. E.	Goshen	Elkhart
Vandevert, Arthur	Sellersburg	Clark
Vandivier, H. R. (H)	Terre Haute	Vigo

Name	City	County
Vandivier, R. M.	Indianapolis	Marion
VanDorn, Myron J.	Indianapolis	Marion
VanFleet, Josephine	Indianapolis	Marion
Van Kirk, George H.	Kentland	Jasper-Newton
VanKirk, J. A.	Frankfort	Clinton
VanKirk, John R.	Burlington	Carroll
VanKirk, Paul P.	Frankfort	Clinton
VanMeter, C. Powell	Indianapolis	Marion
VanNess, William C.	Summitville	Madison
VanNest, W. A.	New Smyrna Beach, Fla.	Dekalb
Van Nuys, John D.	Indianapolis	Marion
VanNuys, W. C.	New Castle	Henry
VanOsdol, H. A.	Indianapolis	Marion
Van Rie, L. P.	Mishawaka	St. Joseph
VanTassel, Charles J.	Indianapolis	Marion
VanVactor, Helen D.	Indianapolis	Marion
VanWinkle, Arthur J.	Valparaiso	Porter
Veach, Lester W.	Bainbridge	Putnam
Veach, Richard L.	Bainbridge	Putnam
Veazey, Wm. (H)	Avilla	Noble
Venable, George L.	N. Manchester	Wabash
Venis, Kemper N.	Muncie	Delaware-Blackford
Vermilya, R. W.	Lafayette	Tippecanoe
Verplank, G. L.	Gary	Lake
Viehe, Robert W.	Evansville	Vanderburgh
Vietzke, P. C. F.	Valparaiso	Porter
Viney, Charles L.	Logansport	Cass
Visher, John S.	Evansville	Vanderburgh
Visher, John W.	Evansville	Vanderburgh
Vlaskamp, Elaine	Muncie	Delaware-Blackford
Vogel, L. John	Mt. Vernon	Posey
Voges, Edward C.	Terre Haute	Vigo
Voisinet, R. A.	Union City	Randolph
Vollrath, Victor J.	Indianapolis	Marion
VonAsch, George	LaPorte	LaPorte
Vore, Hugh A.	East Chicago	Lake
Vore, L. W.	Plymouth	Marshall
Voyles, C. F. (H)	Indianapolis	Marion
Voyles, Harry	New Albany	Floyd

W

Name	City	County
Wade, A. A.	Howe	LaGrange
Wagner, Arthur L.	Indianapolis	Marion
Wagoner, G. W.	Delphi	Carroll
Wagoner, James M.	Jasper	Dubois
Wagoner, John B.	Colburn	Tippecanoe
Wagoner, Robert H. (H)	Colburn	Tippecanoe
Waite, Earl L.	Macy	Miami
Waite, Richard R.	Lafayette	Tippecanoe
Waldo, J. Thayer	Indianapolis	Marion
Wales, E. DeWolfe (H)	Indianapolis	Marion
Walker, Adolph B.	Whiting	Lake
Walker, F. C.	Indianapolis	Marion
Walker, Floyd	Fort Wayne	Allen
Walker, Jack M.	Knightstown	Henry
Walker, J. L.	LaFontaine	Wabash
Walker, Robert K.	Indianapolis	Marion
Wall, Joseph A.	Wabash	Wabash
Wallace, Hawthorne C.	Crawfordsville	Montgomery
Waller, John I.	Indianapolis	Marion
Walters, Charles E.	Mishawaka	St. Joseph
Walters, William	Michigan City	LaPorte
Walther, Joseph E.	Indianapolis	Marion
Wanninger, Horace	Richmond	Wayne-Union
Ward, H. H.	Coalmont	Clay
Ward, J. W.	Mishawaka	St. Joseph
Ward, Jos. H.	Indianapolis	Marion
Ward, Wesley C.	Indianapolis	Marion
Ware, J. R.	Huntington	Huntington
Warfel, F. C.	Indianapolis	Marion
Warfield, Chester H.	Ft. Wayne	Allen
Warman, A. P.	St. Petersburg, Fla.	Marion
Warn, William J.	Milan	Ripley
Warne, G. H.	Tipton	Tipton
Warren, Bradford	Marshall	Parke-Vermillion
Warren, Carroll B.	Marion	Grant
Warren, John C.	Indianapolis	Knox
Warrick, Francis B.	Richmond	Wayne-Union
Warrick, Homer L.	Osceola	St. Joseph
Warriner, James B.	Indianapolis	Marion
Warvel, J. H.	Indianapolis	Marion
Washburn, W. W.	Lafayette	Tippecanoe
Wasley, Malcolm T.	Whittier, Cal.	Delaware-Blackford
Waterman, John H.	Indianapolis	Marion
Waymire, E. S.	Indianapolis	Marion
Weathers, Paul E.	Barksdale, La.	Marion
Weaver, T. M. (H)	Brazil	Clay
Weaver, Wm. W.	New Albany	Floyd
Webb, Harry D.	Anderson	Madison
Weber, Edgar H.	Evansville	Vanderburgh
Weber, John R.	Ft. Wayne	Allen
Weber, Joseph G. S.	Terre Haute	Vigo
Webster, R. K.	Brazil	Clay
Weddle, Chas. O.	Lebanon	Boone
Weeks, P. H.	Michigan City	LaPorte
Weems, M. P.	Jeffersonville	Clark
Wehrman, J. O. (H)	Indianapolis	Marion
Weigand, C. G.	Indianapolis	Marion
Weil, H. J.	Indianapolis	Marion
Weiland, Albert S.	Chicago, Ill.	Lake
Weinberg, B. A.	Whiting	Lake
Weinberg, Samuel	Marion	Grant
Weinland, George C.	Indianapolis	Marion
Weinstein, E. B.	Richmond	Wayne-Union
Weinstein, J. H.	Terre Haute	Vigo
Weinstock, Adolph	Rolling Prairie	LaPorte
Weir, Dale	LaGrange	LaGrange
Weirich, Charles I.	Butler	Dekalb
Weis, William D. (H)	Crown Point	Lake
Weiskopf, Henry S.	Gary	Lake
Weiss, Eugene	South Bend	St. Joseph
Weiss, H. G.	Evansville	Vanderburgh
Weiss, Jason	Indianapolis	Marion
Weitzel, Roland	Princeton	Gibson
Welborn, Mell B.	Evansville	Vanderburgh
Welch, Norbert M.	Vincennes	Knox
Weldy, Bryce P.	Hartford City	Delaware-Blackford
Weller, Charles A.	Indianapolis	Marion
Welty, S. G.	Ft. Wayne	Allen
Werry, L. E.	Hartford City	Delaware-Blackford
Wertenberger, Morris D.	Richmond	Wayne-Union
Wesson, Thomas W.	Evansville	Vanderburgh
West, Joseph L.	Indianapolis	Marion
Westerbeck, Charles W.	St. Meinrad	Perry
Westfall, B. Kemper	Indianapolis	Marion
Westfall, George S.	Goshen	Elkhart
Westfall, John B.	Indianapolis	Marion
Weyerbacher, A. F.	Indianapolis	Marion
Whallon, Arthur J.	Richmond	Wayne-Union
Wharton, R. O.	Gary	Lake
Wheeler, J. T. (H)	Indianapolis	Marion
Whipps, Charles E.	Carlisle	Sullivan
Whisler, F. M.	Wabash	Wabash
Whitcomb, Roger F.	Shelbyville	Shelby
White, C. S.	Rosedale	Parke-Vermillion
White, Donald J.	Indianapolis	Marion

Name	City	County
White, Harvey E.	Farmland	Randolph
White, I. D. (H)	Clinton	Parke-Vermillion
White, James V.	Terre Haute	Vigo
White, W. J. (H)	Gary	Lake
Whitehead, John M.	Indianapolis	Marion
Whitlock, Francis C.	Indianapolis	Marion
Whitlock, Merle E.	Mishawaka	St. Joseph
Whitsitt, S. A. (H)	Madison	Jefferson
Whitt, James D.	Indianapolis	Marion
Wicks, O. C. (H)	Gary	Lake
Wiedemann, F. E. (H)	Terre Haute	Vigo
Wiethoff, Clifford Allen	Indianapolis	Marion
Wiggins, D. S. (H)	New Castle	Henry
Wiggins, George	New Castle	Henry
Wilber, H. R.	Jeffersonville	Clark
Wilcox, R. F.	LaPorte	LaPorte
Wilder, G. B.	Anderson	Madison
Wildman, R. E.	Peru	Miami
Wiley, William M.	Shelbyville	Shelby
Wilhelm, Agatha M.	South Bend	St. Joseph
Wilhelmus, C. Kenneth	Evansville	Vanderburgh
Wilhelmus, Charles M.	Newburgh	Warrick
Wilhelmus, Gilbert	Evansville	Vanderburgh
Wilhelmus, Wm. M.	Evansville	Vanderburgh
Wilkens, I. W.	Indianapolis	Marion
Wilkerson, Edward L.	Terre Haute	Vigo
Wilkins, R. W.	Ft. Wayne	Allen
Wilkinson, Roger L.	Anderson	Madison
Willan, H. R.	Martinsville	Morgan
Williams, A. H.	Ft. Wayne	Allen
Williams, Alexander S.	Gary	Lake
Williams, Berniece	Ft. Wayne	Allen
Williams, Charles D.	Indianapolis	Marion
Williams, C. L.	Marion	Grant
Williams, Everett W.	Columbus	Bartholomew-Brown
Williams, F. M., Jr.	Anderson	Madison
Williams, F. P.	Huntingburg	Dubois
Williams, Frederic N.	Mt. Vernon	Posey
Williams, H. O.	Kendallville	Noble
Williams, H. S., Jr.	Indianapolis	Marion
Williams, John H.	Muncie	Delaware-Blackford
Williams, Luther (H)	Indianapolis	Marion
Williams, Paul D.	Richmond	Wayne-Union
Williams, Robert D.	Indianapolis	Marion
Williams, R. H.	Anderson	Madison
Willis, Charles F.	Evansville	Vanderburgh
Willison, George	Evansville	Vanderburgh
Willner, Alan	Clarksville	Clark
Wills, Benjamin F.	Union City	Randolph
Wills, Max	Auburn	DeKalb
Willson, C. L.	Anderson	Madison
Wilmore, Ralph C.	Indianapolis	Marion
Wilson, Fred	Terre Haute	Vigo
Wilson, Guy	Bicknell	Knox
Wilson, James	South Bend	St. Joseph
Wilson, John D.	Evansville	Vanderburgh
Wilson, Leslie	Ft. Wayne	Allen
Wilson, O. E.	Elkhart	Elkhart
Wilson, Oliver R.	Indianapolis	Marion
Wilson, Paul	Boonville	Warrick
Wilson, P. H.	Logansport	Cass
Wilson, R. C.	Franklin	Johnson
Wilson, Ralph	Evansville	Vanderburgh
Wilson, Ralph (H)	Shirley	Henry
Wilson, Roland B.	Ft. Wayne	Allen
Wilson, T. L.	Bloomington	Owen-Monroe
Wiltshire, J. W. (H)	Bloomington	Owen-Monroe
Wimmer, G. G.	Mt. Etna	Huntington
Wimmer, Robert N.	Gary	Lake
Winter, Donald K.	Logansport	Cass
Winters, Matthew	Indianapolis	Marion
Wise, Charles L.	Camden	Carroll
Wise, Wm.	Indianapolis	Marion
Wiseheart, O. H. (H)	North Salem	Hendricks
Wiseheart, Robert	Lebanon	Boone
Wiseman, V. Earle	Greencastle	Putnam
Wisener, G. H.	Richmond	Wayne-Union
Wishard, Wm. N., Jr.	Indianapolis	Marion
Wishart, S. W.	Evansville	Vanderburgh
Wissman, William L.	Columbus	Bartholomew-Brown
Witham, Robert L.	Culver	Marshall
Wixted, John F.	Mishawaka	St. Joseph
Wixted, Julia F.	Mishawaka	St. Joseph
Wohlfeld, J. B.	Bedford	Lawrence
Wolfe, Nelson	New Albany	Floyd
Wolfram, Don J.	Indianapolis	Marion
Woner, John W.	Linton	Greene
Wood, Amelia T.	Muncie	Delaware-Blackford
Wood, Donald E.	Indianapolis	Marion
Wood, Opal L.	Brazil	Clay
Wood, R. W.	Oakland City	Gibson
Wood, W. H.	Evansville	Vanderburgh
Woodard, Abram S., Jr.	Indianapolis	Marion
Woodcock, C. E.	Greenwood	Johnson
Woods, A. L.	Poseyville	Posey
Woods, H. C.	Markle	Huntington
Woods, James R.	Greenfield	Hancock
Woods, Wm. P.	Evansville	Vanderburgh
Woolery, R. H.	Bedford	Lawrence
Work, Bruce A.	Frankfort	Clinton
Work, James A., Jr.	Elkhart	Elkhart
Worley, A. C.	Ft. Wayne	Allen
Worley, J. P.	Indianapolis	Marion
Worth, C. W.	Milroy	Rush
Wright, Cecil S.	Anderson	Madison
Wright, E. D.	Seymour	Jackson
Wright, J. Wm., Jr.	Indianapolis	Marion
Wright, J. William	Indianapolis	Marion
Wright, W. C.	Ft. Wayne	Allen
Wurster, H. C.	Mishawaka	St. Joseph
Wyatt, Fred H.	Denver, Colorado	Vanderburgh
Wyatt, James L., II	Ft. Wayne	Allen
Wyatt, James L., III	Ft. Wayne	Allen
Wyeth, Charles (H)	Terre Haute	Vigo
Wygant, M. D.	Mishawaka	St. Joseph
Wyland, B. J.	Mishawaka	St. Joseph
Wynn, J. F.	Evansville	Vanderburgh
Wynne, R. E.	Bedford	Lawrence
Wyttenbach, Frederick	Indianapolis	Marion
Wyttenbach, John E.	Indianapolis	Marion

Y

Name	City	County
Yarling, J. E. (H)	Peru	Miami
Yarrington, C. W.	Gary	Lake
Yeck, Charles W.	Evansville	Vanderburgh
Yegerlehner, Roscoe	Kentland	Jasper-Newton
Yencer, M. W. (H)	Richmond	Wayne-Union
Yochem, August S., Jr.	Indianapolis	Marion
Yocum, Boaz (H)	Coal City	Owen-Monroe
Yocum, Paul S.	Gary	Lake
Yocum, William S.	Gary	Lake
Yoder, Albert C.	Goshen	Elkhart
Yoder, D. D.	Columbus	Bartholomew-Brown
Yoder, Richard P.	Bluffton	Wells
York, Arthur F.	Anderson	Madison
Young, E. M. (H)	Sheridan	Hamilton

Name	City	County
Young, G. M.	Gary	Lake
Young, G. S.	Muncie	Delaware-Blackford
Young, James W.	Indianapolis	Marion
Young, John M.	Indianapolis	Marion
Young, Ralph H.	Goshen	Elkhart
Young, Robert	Marion	Grant
Young, S. J. (H)	Kendallville	Noble
Young, W. C.	Indianapolis	Marion
Yung, J. Rudolph	Terre Haute	Vigo
Yunker, P. E.	Evansville	Vanderburgh
Z		
Zaring, B. K.	Columbus	Bartholomew-Brown
Zehr, Noah	Ft. Wayne	Allen
Zeiger, Irvin	South Bend	Jasper-Newton
Zell, Evertson H.	Indianapolis	Marion
Zeman, Theodore C.	Hammond	Lake
Zeps, E. Frances	Indianapolis	Marion
Zerfas, Charles P. A.	Indianapolis	Marion
Zerfas, L. G.	Camby	Sullivan
Zerfas, Phyllis	Indianapolis	Marion
Zierer, R. O.	Anderson	Madison
Zimmer, Henry J.	Mishawaka	St. Joseph
Zimmerman, Harold	Evansville	Vanderburgh
Zimmerman, Wm. H.	Dublin	Henry
Zink, Robert O.	Madison	Jefferson
Ziperman, H. Haskell	Indianapolis	Marion
Zweig, E. S.	Ft. Wayne	Allen
Zwerner, Paul F.	Terre Haute	Vigo
Zwick, Harold F.	Decatur	Adams
Zwickel, R. E.	Merion Station Pa.	Warrick

ROSTER OF MEMBERS BY COUNTIES

Physicians are listed in the counties in which they reside.

(Paid up members of the Indiana State Medical Association as of June 1, 1950)

ADAMS COUNTY

Beaver, Norman .....Berne
Habegger, Myron L.....Berne
Jones, D. D. (H).....Berne
Lehman, Harold .....Berne
Reusser, Amos (H) .....Berne
Burk, James M. .....Decatur
Carroll, John C. .....Decatur
Duke, Benjamin E.....Decatur
Girod, Arthur H. .....Decatur
Kohne, Gerald J. .....Decatur
Parrish, Richard K. .....Decatur
Rayl, Claudius C. .....Decatur
Reppert, Roland L. .....Decatur
Smith, Waldo E. (H).....Decatur
Terveer, John B. .....Decatur
Zwick, Harold F. .....Decatur
Hinchman, Clarence P.....Geneva
Schetgen, Joseph V. .....Geneva

ALLEN COUNTY

Fort Wayne

A

Adams, John R...621 W. Berry (2)
Aiken, Arthur F.....1923 E. State
Aiken, Nevin E....1923 E. State St.

B

Bailey, Paul P.
206 Wayne Phar. Bldg. (2)
Baltes, Jos. H....721 Broadway (2)
Bartholomew, Alfred C.
405 Dime Bank Bldg. (2)
Bash, Wallace E.....111 Esmond
Baumgartner, J. C.
618 Wayne Phar. Bldg. (2)
Beams, Ralph
517 Wayne Phar. Bldg. (2)
Beierlein, Karl M.
629 Wayne Phar. Bldg. (2)
Benninghoff, D. R.
208 Wayne Phar. Bldg. (2)
Berghoff, R. J., 306 E. Jefferson (2)
Bickel, J. E...2615 S. Lafayette (2)
Blosser, H. V. (H).309 W. Main (2)
Bolman, Ralph M..618 W. Berry St.
Borders, Theodore R.
1145 S. Lafayette (2)
Bowers, G. T...307 E. Jefferson (2)
Bowers, J. W.....418 Gettle Bldg.
Brosius, R. H. W....1603 Wells (7)
Brown, F. W...335 Lincoln Bk. Tr.
Bruggeman, H. O.
604 Wayne Phar. Bldg. (2)
Bryan, Franklin A.
402 W. Washington Blvd.
Buckner, Doster
533 W. Washington St.
Bulson, Eugene L.
102 Wayne Phar. Bldg. (2)

C

Calvin, J. C. (H).312 W. Wayne (2)
Cameron, Don F.
702 Wayne Phar. Bldg. (2)
Carey, Willis W. (H)
2525 S. Calhoun (5)
Carlo, E. R.....2902 Fairfield (6)
Cartwright, E. L.
230 Wayne Phar. Bldg. (2)
Catlett, M. B....232 W. Wayne (2)
Chambers, A. R..601 W. Wayne (2)
Clark, W. R....3622 S. Calhoun St.
Conley, J. E.....620 W. Berry (2)
Cooney, C. J.....527 W. Berry (2)
Cornell, B. S....435 Lincoln Bk. Tr.
Craig, R. M...116 W. Rudisill Blvd.
Culp, J. E.....2902 Fairfield (6)

D

Dancer, C. R. (H)
228 Wayne Phar. Bldg. (2)
Ditton, I. W.(H).1214 E. Wayne (4)
Duemling, A. H..2902 Fairfield (2)
Dunstone, H. C.
502 Wayne Phar. Bldg. (2)

E

Eberly, Karl C.
310 Wayne Phar. Bldg. (2)
Edlavitch, B. M....716 Rockhill (2)
Elston, Lynn W.
622 Wayne Phar. Bldg. (2)
Elston, Ralph W.
622 Wayne Phar. Bldg. (2)
Estlick, R. E.
629 Wayne Phar. Bldg. (2)

F

Ferguson, A. N...2902 Fairfield (6)
Fichman, A. M...323 W. Berry (2)
Foy, H. W.....1747 Wells St.

G

Garton, H. W.....1635 Broadway
Gerding, W. J....2638½ S. Calhoun
Gessler, W. F....2902 Fairfield (6)
Gladstone, N. H...335 W. Berry (2)
Glock, H. E.
324 Wayne, Pharm. Bldg. (2)
Glock, M. E.....312 W. Wayne (2)
Glock, W. R..335 Lincoln Bk. Tower
Gould, L. K....3415 S. Fairfield (6)
Graham, George M.
Lincoln Nat. Life Ins. Co.

ALLEN COUNTY

(Fort Wayne—Continued)

H

Haffner, H. G. 202 E. Jefferson (2)
Hamilton, E. D.
2405 Florida Dr. (3)
Harshman, L. P.
2704 N. Clinton (3)
Harvey, H. C. . . . 1202 E. State (3)
Hasewinkle, A. M. . 1129 E. State (3)
Hastings, Warren C. 811 Ewing St.
Hattendorf, A. P.
725 Wayne Phar. Bldg. (2)
Havens, R. E.
1845 Kensington Blvd.
Hiatt, Russell L. Veterans Hospital
Hoffman, A. F. . . . 233 E. Jefferson
Hoffmann, S. P.
424 Wayne Phar. Bldg. (2)
Holsinger, Robert E.
832 E. Creighton (5)
Horton, G. R. . . . . 527 W. Berry St.
Howe, F. L. . . . . 1525 Oxford St.

J-K

Jurgensen, W. T. . . . . 3415 Fairfield
Kent, Richard N.
731 Wayne Phar. Bldg. (2)
Kidder, O. T. . . . . Irene Byron San.
Kissinger, Charles C.
Veterans Hospital
Kruse, E. H. . . . 705 Lincoln Tr. (2)
Kruse, Walter E.
512 Wayne Phar. Bldg. (2)

L

Ladig, D. S. . . . . 337 E. Berry (2)
Lehner, J. J.
323 Wayne Phar. Bldg. (2)
Lenk, G. G. . . . . 2007 Maumee (4)
Lloyd, R. P. . . . . 3418 S. Hanna St.
Lohman, R. M.
229 Wayne Phar. Bldg. (2)
Loudermilk, Jack L.
525 Wayne Phar. Bldg. (2)

M

Martineau, P. C. . . . Lutheran Hosp.
McArdle, E. G. . 2201 S. Calhoun (5)
McCabe, T. E. . . . . 1001½ Broadway
McCoy, R. R. . . 3701 S. Harrison (6)
McDowell, G. A.
215 Wayne Phar. Bldg. (2)
McEachern, Cecil G.
701 Wayne Phar. Bldg (2)
McKeeman, Donald H.
633 W. Wayne St. (2)
McKeeman, L. S.
304 Wayne Phar. Bldg. (2)
McNairy, Donald J.
710 Wayne Phar. Bldg. (2)
Mendenhall, Edgar
208 Wayne Phar. Bldg. (2)
Mercer, Samuel R.
710 Wayne Phar. Bldg. (2)
Meyer, H. A. . . . 1030 W. Wayne (2)
Meyer, T. O. . . . . 445 Lincoln Tr.
Michaelis, S. C. . . 2154 Fairfield (6)
Miller, C. G. . . . . 320 W. Wayne (2)
Miller, H. Paul . . . . . 2809 Broadway
Miller, Mahlon F.
334 Wayne Phar. Bldg. (2)
Miller, O. J. . . . . 324 W. Berry (2)
Miller, R. H. . . . . 511 W. Wayne (2)
Miller, W. J. . . . . 310 E. Washington
Moats, C. F. . . . . 4007 S. Wayne (6)
Moats, G. E. . . . . 421 E. Wayne (2)
Moravec, A. E. . 705 Lincoln Tr. (2)
Mortenson, L. J.
214 Wayne Phar. Bldg. (2)
Mueller, L. W. . . . . 533 W. Wash.
Murdock, H. L.
521 Wayne Phar. Bldg. (2)

N-O

Nahrwold, E. W.
417 Wayne Phar. Bldg. (2)
Nill, J. H. . . . . 1024 S. Barr (2)
O'Rourke, C. . . . . 604 W. Berry (2)
Oyer, J. H. . . . 2707½ S. Calhoun St.

P

Painter, Donald S.
334 Wayne Phar. Bldg. (2)
Parker, C. B. . . 1105 S. Harrison St.
Perrin, K. F. . . 2701 S. Anthony St.
Perry, F. G. . . . . 2902 Fairfield (6)
Popp, Milton F.
610 Wayne Phar. Bldg. (2)
Porter, Miles F., Jr.
501 Dime Bank Bldg. (2)
Prentiss, Nelson H.
276 Central Bldg. (2)

Q-R

Rabson, S. M. . . . . 730 W. Berry St.
Ranke, John W. Henry (H)
3112 Beaver Ave. (6)
Rawles, L. T. . . . . 3131 Fairfield (6)
Rice, W. B. . . . . 1101 E. Pontiac (5)
Rissing, W. J. . . . 1706 Sherman (7)
Rockey, N. A. . . . . 1224 E. State (3)
Rodriguez, J. . . 2902 S. Fairfield (6)
Roser, A. J. . . . . 617 W. Washington
Rossiter, D. L. . . . 1032½ E. Pontiac
Rothberg, Maurice
712 Wayne Phar. Bldg. (2)
Rothschild, C. J.
319 Wayne Phar. Bldg. (2)
Ryan, W. J. J. . . . . 1536 S. Calhoun

S

Sahlmann, H. . . 1320 Broadway (2)
Salon, H. W. . . . . 535 W. Berry (2)
Salon, Nathan L.
220 Wayne Phar. Bldg. (2)
Savage, A. R. . . . . 302 W. Berry (2)
Schafer, D. W. . . . 221 W. Wayne St.
Schellhouse, Earl . . . . 1240 W. Main
Schick, Martin F. (H)
401 W. Washington (2)
Schlademan, Karl R.
516 Wayne Phar. Bldg. (2)
Schlegel, Edward H. . 1129 Maumee
Schmoll, R. J. . . . . 604 W. Berry St.
Schneider, L. H. . St. Joseph's Hosp.
Schoen, Frederic L.
220 Wayne Phar. Bldg. (2)
Scoins, W. H. . . . . 1301 S. Harrison
Scott, H. V. . . . . 2902 Fairfield (6)
Senseny, Herbert
314 Wayne Phar. Bldg. (2)
Shinabery, L. . . . 1850 Broadway (6)
Short, J. T. . . . . 2902 Fairfield (6)
Singer, Elmer C.
310 Wayne Phar. Bldg. (2)
Somers, Gerald H.
2506 Lower Huntington Rd. (8)
Sparks, A. Jerome . . Veterans Hosp.
Stauffer, R. C.
418 Wayne Phar. Bldg. (2)
Stellner, H. . . . . 324 W. Berry St.
Stier, Paul L.
304 Wayne Phar. Bldg. (2)
Stoler, A. E. . . . . 278 Central Bldg.

T

Tennant, D. L. . . . . 1832 S. Calhoun
Tennant, Lewis W. (H)
3409 Clinton Court
Terrill, R. W. . . . 455 Lincoln Tr. (2)
Thimlar, J. W. . . . . 602 E. Lewis (2)
Thompson, H. . . . . Irene Byron San.
Thornton, Walter E.
Lincoln Nat. Life Ins. Co.

W

Walker, Floyd B. . . . 610 E. Pontiac
Warfield, C. H. . . . St. Joseph Hosp.
Weber, John R.
417 Wayne Phar. Bldg.
Welty, S. G. . 2702½ S. Calhoun (5)
Wilkins, R. W. . . . 2902 Fairfield (6)
Williams, A. B. . 3526 N. Wash. Rd.
Williams, A. H. . . 2902 Fairfield (6)
Wilson, Leslie . . . . . Veterans Hosp.
Wilson, R. B. . 1207 S. Lafayette (2)
Worley, Ansel C.
317 Wayne Phar. Bldg. (2)
Wright, Wm. C.
621 Wayne Phar. Bldg. (2)
Wyatt, James L. III
233 E. Jefferson St. (2)
Wyatt, J. L. II . 232 E. Jefferson (2)

X-Y-Z

Zehr, Noah . . . 301 W. Creighton (6)
Zweig, E. S. . . . . 344 W. Berry (2)

Emme, Richard W. . . . . Harlan
Steinman, Henry E. . . . . Monroeville
Uhrich, John . . . . . Monroeville
Dahling, C. W. . . . . New Haven
Emenhiser, Donald C. . . New Haven
Emenhiser, John L. . . . . New Haven
Hoetzer, Eldore M. . . . . New Haven
Smith, Grover A. . . . . New Haven
Smith, Richard B. . . . . New Haven
Smith, Roger C. . . . . New Haven
DeVoe, Kenneth . . . . . Woodburn
Moser, Edward (H)
Box 65, Woodburn
Draper, Merlin H.
Drew Field T. B. Sanitarium,
Tampa, Fla.
Havice, Jay F.
Millbrook No. 56, Lake Lure, N.C.

BARTHOLOMEW-BROWN COUNTIES

Columbus

Adler, David L.
Bartholomew County Hospital
Beggs, Lowell F.
633 Washington St.

BARTHOLOMEW-BROWN COUNTIES

(Columbus—Continued)

Carpenter, Thomas D.
725 Washington St.
Davis, Marvin R.
814 Washington St.
Fisher, Walter S.....422 9th St.
Hart, Robert B.
712 Washington St.
Hawes, James K. (H)
633 Washington St.
Hawes, Marvin E.
633 Washington St.
Henry, Alvin L.....Columbus
Macy, George W.
633 Washington St.
Marr, Griffith..633 Washington St.
Norton, Harold J.
633 Washington St.
Overshiner, Lyman
633 Washington St.
Ritteman, George W.
Bartholomew County Hospital
Ryan, William J.
633½ Washington St.
Schmitt, Richard K.
437 Washington St.
Sigmund, William B.
718 Washington St.
Teal, Dorothy Denzle
728 Franklin St.
Williams, Everett W.
725 Washington St.
Wissman, William L.
725 Washington St.
Yoder, Dewey D.
725 Washington St.
Zaring, Byron K.
641 Washington St.

Dudding, Joseph E.....Hope
Schneider, Kenneth.....Nashville

BENTON COUNTY

Taylor, Wade H.....Ambia
Atkinson, Charles W.....Boswell
Leak, Robert .....Boswell
Carnes, Wm. M.....Earl Park
Altier, William H.....Fowler
Turley, Verne L.....Fowler
McCabe, James E.....Otterbein
Smith, Charles G.....Otterbein
Parker, Ernest E.....Oxford
Scheurich, Virgil .....Oxford

BLACKFORD COUNTY

(See Delaware-Blackford)

BOONE COUNTY

Riley, Frank H.....Jamestown
Schaaf, Alvin D.....Jamestown
Ballard, Robert J.....Lebanon
Beck, Herma A.....Lebanon
Coons, John D.....Lebanon
Coons, Ritchie .....Lebanon
Headley, Lloyd M.....Lebanon
Higgins, Otis C.....Lebanon
Honan, Paul R.....Lebanon
Kern, Clarence G.....Lebanon
Porter, Jack .....Lebanon
Porter, John R.....Lebanon
Rainey, Everett A.....Lebanon
Spieth, William H.....Lebanon
Weddle, Charles O.....Lebanon
Wiseheart, Robert H.....Lebanon
Bassett, Clancy .....Thorntown
Bassett, Margaret A....Thorntown
Gregg, Edwin E.....Thorntown
Bailey, Lawrence S.....Zionsville
Harvey, Ralph J.....Zionsville
Johns, Elmer.....Zionsville
Lovett, Harvey .....Whitestown

BROWN COUNTY

(See Bartholomew-Brown)

CARROLL COUNTY

VanKirk, John R.....Burlington
Kennedy, Eva N.....Camden
Wise, Charles L.....Camden
Brown, Thomas .....Delphi
Crampton, Charles C. (H)..Delphi
Gros, Hubert .....Delphi
Wagoner ,George W.....Delphi
Adams, Max R.....Flora
Brookie, Roger Wm.....Flora
McLaughlin, James R.....Flora

CASS COUNTY

Dutchess, C. Toney.....Galveston

Logansport

Adamski, Michael....408 North St.
Bailey, Earl W.....212 Fifth St.
Ballard, Chas. A...325½ E. Market
Bradfield, John C....408 North St.
Cooper, Thomas L...408 North St.
Davis, John C.....Masonic Temple
Fitzgerald, Brice E..2127 North St.
Hall, Bernard R.....415 North St.
Hedde, Eugene L...309 Seventh St.
Hickman, Warren R...211 S. Third
Hillis, Lowell J.....203 S. Third
Hochhalter, M....307 Barnes Bldg.
Hogle, F. D...Logansport St. Hosp.
Holloway, W. A. (H)..201 S. Third
Holmes, W. W.....Masonic Temple
Jewell, Earl B.....3019 S. Penn St.
Jones, J. Carl.....422 North St.
Keefe, Thomas L.....216 Ninth St.
Larson, John A.....State Hosp.
Lemon, H. K.....State Hosp.
Maxwell, John B. (H)
431½ E. Broadway
Morrical, Russell S...212 Fifth St.
Morrow, George W.....State Hosp.
O'Leary, F. T....94 Eel River Ave.
Schenk, Foss .Logansport St. Hosp.
Shultz, Harry M.....412 Fourth St.
Stanton, Jas. J.....220 S. Sixth St.
Stewart, Milton B. (H)
308½ Fourth St.
Terflinger, Fred W. (H)
422 North St.
Viney, Charles L...Masonic Temple
Wilson, Paul H.....422 North St.
Winter, Donald K....422 North St.

Newcomb, Wm. K....Royal Center
Rollins, Russell .....Royal Center
Flanagan, Estle P.....Walton
Lybrook, Daniel E..Young America

CLARK COUNTY

Stalker, John M.....Borden
Bottorff, David .....Charlestown
Goodman, Eli .....Charlestown
Patterson, Cecil .....Charlestown
Willner, Alan .....Clarksville
Greene, William R.....Henryville

Jeffersonville

Adair, Samuel L...112 W. Court St.
Baldwin, J. H.....425 Meigs Ave.
Bizer, Mier.....402 Spring St.
Bruner, Ralph W....437 Spring St.
Buckley, Ernest P.
446 N. Norwood Ave.
Carlberg, Dale.....442 Spring St.
Carney, Joel T.....344 Spring St.
Dare, Lee A.....105 W. Maple St.
Forsee, Norman E...456 Spring St.
Huoni, John S.....105 W. Maple St.
Isler, Nathaniel C...521 Spring St.
Mercer, Herman....452 Spring St.
Weems, Mallory P...404 Spring St.
Wilber, Harold R....437 Spring St.

Regan, George L.....Sellersburg
Sturgis, D. G.....Sellersburg
Vandervert, Arthur C..Sellersburg

CLAY COUNTY

Maurer, J. Frank.....Brazil
Maurer, Robert M.....Brazil
Palm, John M.....Brazil
Shattuck, John C.....Brazil
Sourwine, Clint C.....Brazil
Weaver, Timothy M. (H)...Brazil
Webster, Robert K.....Brazil
Wood, Opal L.....Brazil
Bond, Walter C.....Clay City
Glosson, Jack R.....Clay City
Ward, Harry H.....Coalmont

CLINTON COUNTY

Frankfort

Applegate, A. E...51 E. Walnut St.
Beardsley, Frank A.
51 S. Jackson St.
Beardsley, John..51 S. Jackson St.
Burroughs, Carroll A.
59 S. Main St.
Carrell, Francis E.
207½ N. Jackson St.
Chittick, A. G....206 E. Walnut St.
Compton, Charles B.
51 S. Jackson St.
Dykhuizen, Theodore A.
59 S. Main St.
Erdel, Milton W.....59 S. Main St.
Hammersley, Geo. K.
361 E. Clinton St.
Hedgcock, Robert A.
205 E. Clinton St.
Holmes, Claude, Sr...9½ W. Clinton
Jones, William W.
9½ W. Clinton St.
Michael, Isaac E .361 E. Clinton St.
Robison, Claude A...59 S. Main St.
Stout, Harry T., Jr.....Frankfort
Van Kirk, John A.
204 W. Washington St.
Van Kirk, Paul P.
204 W. Washington St.
Work, Bruce A...47 S. Jackson St.

CLINTON COUNTY
(Continued)

Clevinger, William G.....Kirklin
Carlyle, Ivan E.....Michigantown
Combs, Nelson B.....Mulberry
Kent, John A.....Mulberry
Grove, Robert H.....Rossville
Ketcham, John S.....Rossville
Sibbitt, Joseph E.
528 Geneva, Bellwood, Ill.

CRAWFORD COUNTY

Gobbel, Novy E.....English
Nolan, Robert .....English
Benz, Jesse .....Marengo
Johnson, Jess J.....Milltown
Lynch, Otis R.....Marengo

DAVIESS-MARTIN COUNTIES

Rohrer, James R.....Elnora
Chattin, Robert E.....Loogootee
Lett, Emory B.....Loogootee
Strange, John W.....Loogootee
McCracken, Jacob O...Montgomery
Coleman, H. G.....Odon
Maschmeyer, Robert H.....Shoals
Blazey, Arthur G.....Washington
Burress, Bert O.....Washington
Chattin, Vance J.....Washington
Farris, John J.....Washington
Fox, C. Philip.....Washington
Lindsay, Hamlin B.....Washington
McKittrick, Jack .....Washington
McNaughton, L. M.....Washington
Norton, Horace .....Washington
Rang, Arthur A.....Washington
Rang, Robert H.....Washington
Schafer, Wm. C.....Washington
Schroeder, Henry ....Washington
Shields, Harry A.....Washington
Smoot, Emory B.....Washington

DEARBORN-OHIO COUNTIES

Baker, Leslie M.....Aurora
Duncan, William F. (H)....Aurora
Jackson, John K.....Aurora
Olcott, Charles W.....Aurora
Stewart, Omer H.....Aurora
Treon, James F.....Aurora
McNeeley, Matthew J.....Dillsboro
Elliott, John C.....Guilford
Fagaly, William J...Lawrenceburg
Houston, Fred D....Lawrenceburg
Pfeifer, James M....Lawrenceburg
Streck, Francis A....Lawrenceburg
Vail, George A.....Lawrenceburg
Fessler, Gordon S.....Rising Sun
Manley, Charles N.....Rising Sun
Fletcher, Charles F.....Sunman

DECATUR COUNTY

Tremain, Milton A.....Adams
Acher, Robert P.....Greensburg
Blemker, Russell H.....Greensburg
Callaghan, Winship C..Greensburg
Dickson, Dale D.....Greensburg
Mahuron, Boyd L.....Greensburg
McKee, Harley S.....Greensburg
Miller, James C.....Greensburg
Morrison, Clyde C. (H).Greensburg
Morrison, James T.....Greensburg
Mullikin, Clarence W...Greensburg
Overpeck, Charles ....Greensburg
Harkcom, Harry E.....St. Paul
Porter, Edward A.....Westport

DEKALB COUNTY

Thill, Leonard S.....Ashley
Covell, Harry M.....Auburn
Geisinger, Lewis N.....Auburn
Hines, Archie V.....Auburn
Mettler, Don C.....Auburn
Nugen, Harold .....Auburn
Rogers, Evered E.....Auburn
Sanders, Jesse A.....Auburn
Souder, Bonnell M.....Auburn
Wills, Max .....Auburn
Hathaway, Clayton B.....Butler
Weirich, Charles I.....Butler
Jinnings, Loren E.....Garrett
Kantzer, Floyd B.....Garrett
Nason, Robert A.....Garrett
Reynolds, D. Monroe.....Garrett
Reynolds, Russell P.....Garrett
Kreischer, Joseph R...Spencerville
Coleman, Floyd B.....Waterloo
Showalter, John P.....Waterloo
Van Nest, Willard A.
New Smyrna Beach, Fla.

DELAWARE-BLACKFORD COUNTIES

Brown, Stewart D.....Albany
Puterbaugh, Karl E.....Albany
Craigmile, Thomas .....Cowan
Hurley, John R.....Daleville
Tucker, Oral A.....Daleville
Ames, George F. (H).....Eaton
Ko, Richard.....Eaton
Downard, Leland F.....Gaston
Langsdon, Fred R.....Gaston
Dando, G. H. (H)...Hartford City
Dodds, Jas. U.....Hartford City
Jackson, Dean B.....Hartford City
Hoffman, Herman ...Hartford City
Owsley, C. E. M.....Hartford City
Owsley, Guy A.....Hartford City
Parks, George.....Hartford City
Weldy, Bryce P.....Hartford City
Werry, Leslie E.....Hartford City
Burns, Paul E.....Montpelier
Douglas, William T.....Montpelier
Taylor, James A. (H)..Montpelier

Muncie

Adams, W. B.....Ball Mem. Hosp.
Alvey, C. R.....417 Wysor Bldg.
Ball, Clay A.....303 W. Adams
Ballard, John E...Ball Mem. Hosp.
Bibler, Henry E.....311 W. Adams
Botkin, C. G.....508 W. Jackson
Botkin, Thos.....1625½ University
Bowles, J. H.....417 Wysor Bldg.
Brown, K. T.(H).247 Johnson Bldg.
Brown, Leland G.
104 West. Res. Bldg.
Brown, Thomas M.
104 West. Res. Bldg.
Butterfield, R. M...315 W. Jackson
Clauser, E. H. M...315 S. Jefferson
Clevenger, J. H....424 W. Jackson
Cole, R. E.....203 West. Res. Bldg.
Covalt, W. E.....216 S. High St.
Cure, E. T.....105 West. Res. Bldg.
Davis, Edgar C.....107 Plaza Bldg.
Deutsch, Wm....309 Johnson Bldg.
Dunn, F. W.....118 S. Franklin
Egbert, Clarence H....2010 S. Vine
Fitch, Ray T.....1708 W. Jackson
Funk, John W.....217 W. Charles
Galliher, M. J.....115 S. Liberty
Garling, L. C...420 W. Washington
Gill, Thos. A.....808 W. Jackson
Greiber, M. F...420 W. Washington
Gustafson, Milton..808 W. Jackson
Hall, Orville A....514 Wysor Bldg.
Hayes, T. R.....210 S. High
Henderson, R. A.....806 W. Main
High, Ralph L..420 W. Washington
Hill, Howard E.....402 W. Jackson
Hill, Robert E.....215 W. Jackson
Hostetter, Irwin S...115 N. Cherry
Hurley, Anson G....110 N. Cherry
Imhof, Jos. D..206 West. Res. Bldg.
Kammer, G. C..420 W. Washington
Kammer, W. F..420 W. Washington
Kemper, A. T. (H)..112 W. Adams
Kern, C. B. (H).715 E. Washington
Kirshman, F. E.....211 S. High
Kuder, Howard V.
420 W. Washington
LaDuron, J. F.....517 S. Liberty
Mason, L. R.....401 W. Jackson
McClellan, John B...613 W. Charles
McClintock, James A.
316 W. Adams
McCoy, George E..417 Wysor Bldg.
McMichael, R. M....324 W. Adams
Molloy, W. J. (H)..310 W. Jackson
Montgomery, Lall G.
Ball Memorial Hospital
Moore, Thos. C.....110 N. Cherry
Moore, Wm. C.....110 N. Cherry
Morris, Jean W..247 Johnson Bldg.
Owens, R. R...406 West. Res. Bldg.
Owens, T. R...202 West. Res. Bldg.
Quick, Wm. J...314 E. Washington
Rettig, Arthur C...314 W. Jackson
Rivers, Glynn A....806 W. Jackson
Schulhof, M. G.....418 W. Wash.
Silvers, Jas. M.....220 W. Adams
Smith, Jas. S.....501 Kirby
Spurgeon, O. E..310 E. Washington
Stocking, B. W....Ball Mem. Hosp.
Tindal, E. F. (H).214 Wysor Bldg.
Tomlin, Hugh M.....921 W. Main
Turner, Robt. D.....217 S. Liberty
Venis, K. N.....101 S. Franklin
Vlaskamp, E. M.....401 W. Main
Williams, J. H.....306 E. Jackson
Wood, Amelia T.....2004 Petty Rd.
Young, G. S.....316 W. Jackson

Moss, Mavor J.....Yorktown
Earl, Max M.....206 E. Chestnut,
Louisville, Ky.
Oster, Ellis....School of Medicine,
Randolph Field, Tex.
Ritchie, Jno. W.....525 W. Isley,
Santa Barbara, Calif.
Rose, Stuart W.....4425 Oxford,
Montreal, Canada
Roth, Bertram..252 S. Brentwood,
Apt. B, Clayton, Mo.
Wasley, Malcolm T.
1455 East Mines Blvd.
Whittier, Calif.

DUBOIS COUNTY

Backer, Henry G.....Ferdinand

DUBOIS COUNTY
(Continued)

Lukemeyer, L. C. (H) Huntingburg
Steinkamp, E. F.....Huntingburg
Stork, Harvey K.....Huntingburg
Williams, F. P.....Huntingburg
Blessinger, Paul J.....Jasper
Held, George A.....Jasper
Klamer, Charles H.....Jasper
Salb, Leo A.....Jasper
Wagoner, James M.....Jasper

ELKHART COUNTY

Horswell, Richard G.....Bristol
Neidballa, Edward G.....Bristol

Elkhart

Arlook, Theo. D..912 W. Franklin
Bender, Robt. L.....411 S. Second
Bloom, Geo. R.....506 S. Second
Bolin, Robt. S.....209 S. Second
Bowdoin, Geo. E.....515 S. Second
Compton, W. A.....2225 Greenleaf
Conklin, R. L.....1906 E. Jackson
Cormican, H. L.....316 S. Fourth
Crandall, L. A..Ames Laboratories
DeDario, L. M.....123 W. Marion
Dewey, Fred N. (H)..127 N. Fifth
Elliott, Lloyd A.....405 S. Second
Fleming, C. F.....121 W. Marion
Fleming, Justus M..123 W. Marion
Hull, Arthur W.....506 S. Second
Hunn, Maro F.....415 S. Second
Kintner, B. E....132 Monger Bldg.
Kistner, A. W.....123 W. Marion
Koehler, Elmer G....Monger Bldg.
Lundt, Milo O.....519 S. Second
Markel, Ivan J....215 W. Franklin
McKee, H. N. (H) 319 Monger Bldg.
Mendez, Carlos.....116 W. Marion
Miller, H. A., Jr.....115 S. Second
Miller, Samuel T.....506 S. Second
Mininger, E. P....413 W. Franklin
Mishkin, Irving.....209 S. Second
Norris, Allen A.....208 W. Marion
Paff, Wm. A.....515 S. Second
Paine, Geo. E.....419 Modrell
Pancost, R. H.....218 Equity Bldg.
Pancost, V. K.....415 S. Second
Patrick, Glenn B.....417 S. Second
Possolt, Thos. R...208 Equity Bldg.
Rohr, Joseph H....1425 E. Jackson
Schlosser, H. C.....116 W. Marion
Sears, M. M.....304 Equity Bldg.
Spray, Page E.....405 S. Second
Stauffer, W. A....214 Equity Bldg.
Stout, R. B....1501 Greenleaf Blvd.
Stubbins, Wm. M.....412 S. Second
Swank, L. F.....315 Equity Bldg.
Swihart, H. R.....121 W. Marion
Swihart, L. F.....214 W. Marion
Wilson, O. E.....217 N. Main
Work, Jas. A., Jr.....412 S. Second

Goshen

Amstutz, H. C.....521 S. Main
Bartholomew, M. L....107 S. Fifth
Bender, C. K....115 E. Washington
Eby, Ida L.....131 S. Main
Freeman, F. M.....109 W. Wash.
Hostetler, C. M.....304 E. Lincoln
Kelly, Wm. R.....210 N. Main
Kinzie, M. Dale.....Shoots Bldg.
Martin, Floyd S.....127 E. Lincoln
Miller, M. E.....Spohn Bldg.
Simmons, L. H.....208 E. Lincoln
VanderBogart, Harry E. 31 Shoots Bldg.
Westfall, Geo. S.....214 E. Lincoln
Yoder, Albert C.....113 S. Fifth
Young, Ralph H....113 E. Madison

Farver, Moses A. (H)..Middlebury
Norris, Ernest B.....Middlebury
Teters, Melvin S.....Middlebury
Chandler, Leon H.....Millersburg
Fleetwood, R. A.....Nappanee
Kendall, Forest M.....Nappanee
Price, Douglas W.....Nappanee
Price, Melvin D. (H)....Nappanee
Price, Willard A. (H)...Nappanee
Slabaugh, Jancy S.....Nappanee
De Fries, John.....New Paris
Stuckman, E. N. (H)...New Paris
Amick, Charles L.....Wakarusa
Hannah, Jack W.....Wakarusa
Elliott, Thomas A..4577 Utopia Dr., New Orleans 20, La.

FAYETTE-FRANKLIN COUNTIES

Foreman, Walter A.....Brookville
Glaser, Robert E.....Brookville
Hoeger, Hobart R.....Brookville
Seal, Perry F.....Brookville
Smith, Herbert N.....Brookville

Connersville

Ashworth, Lewis N.....716 Grand
Cavitt, Robert F.....930 Central
Dale, Maxwell H.....818 Grand
Elliott, Roy H.....602½ Central
Ellis, Geo. M., Jr.....108 E. Tenth
Entner, Charles L.....117 E. Sixth
Gordin, Stanley B.....R. D. 3
Gordin, Stanton E. (H)....R. D. 4
Gregg, Albert F.....124 E. Sixth
Kemp, William A...122 W. Seventh
Lockhart, Jack M.....523 Central
Morrow, Roy D.....621 Central
Mountain, Francis B...620 Eastern
Neukamp, Frank H. American Central Mfg. Co.
Smelser, Herman W....823 Central

Daley, Edward H.....Oldenburg

FLOYD COUNTY

Engleman, Harry K...Georgetown

New Albany

Baker, Avey M.....811 E. Spring
Baxter, Jas. W., Sr..1201 E. Spring
Baxter, Saml. M....1201 E. Spring
Briscoe, C. E.....1413 E. Spring
Brown, Kenneth H...410 E. Spring
Byrn, Howard W...416 Elsby Bldg.
Cannon, Daniel H..216 Elsby Bldg.
Davis, Parvin M.....601 E. Spring
Day, George H.....1252 Vincennes
Dick, Jack .....Route 21
Edwards, William F. Floyd County Bank Bldg.
Garner, Wm. H.....919 E. Spring
Gentile, John P.....1313 E. Spring
Hauss, A. P.....212 Elsby Bldg.
Hess, Paul P.....Lilly Lane
LaFollette, Robt. E.....500 Spring
McCullough, J. Y.....624 E. Spring
Murphy, Edgar W.....1824 State
Pace, Jerome V....Silvercrest San.
Paris, John M.....150 E. Spring
Pierson, Percy R. 203 Liberty State Bank Bldg.
Polhemus, G. I.....1610 E. Spring
Robertson, A. N.....820 E. Spring
Shacklett, Henry B. (H) 117 E. Spring St.
Sloan, Herbert.....1207 E. Spring
Streepey, J. I.....1102 E. Spring
Tyler, Frank T.....420 Vincennes
Voyles, Harry E...213 Elsby Bldg.
Weaver, Wm. W....1104 E. Spring
Wolfe, Nelson.....908 E. Spring

Hofferkamp, August G. Hazelwood Sanitarium, Louisville, Ky.

FRANKLIN COUNTY

(See Fayette-Franklin)

FOUNTAIN-WARREN COUNTIES

Fisher, John E.....Attica
Freed, Carl A.....Attica
Freed, James C.....Attica
Kerr, Alvin R.....Attica
Maris, Lee J.....Attica
Aldridge, James W.....Covington
Johnson, Earl E.....Covington
Stephens, Lowell R.....Covington
Suzuki, T. T.....Covington
Ratcliff, A. Lonzo (H)....Kingman
Smith, Byron J.....Kingman
Himebaugh, G. J.....Veedersburg
McCord, Carl B.....Veedersburg
Rusk, Hubert M.....Wallace
Nelson, Carl A.....West Lebanon
Crain, James W.....Williamsport
Schmiedicke, P. H....Williamsport

FULTON COUNTY

Herrick, Charles L.....Akron
Miller, Virgil .....Akron
Dielman, Franklin C.....Fulton
Kelsey, Lawrence E.....Kewanna
Kraning, Kenneth K.....Kewanna
Glackman, John C.....Rochester
Herendeen, Elbie V.....Rochester
King, Milo O.....Rochester
Richardson, Chas. L.....Rochester
Rowe, Howard H.....Rochester
Stinson, Arthur E.....Rochester
Stinson, Dean K.....Rochester

GIBSON COUNTY

Geick, Raymond G.....Fort Branch
Hollis, Walter.....Fort Branch
Marchand, Austin F.....Haubstadt
Marchand, Edwin V.....Haubstadt
Pettijean, Harold G.....Haubstadt
Arthur, Hamilton M. (H) Hazelton
Turner, Maurice.....Oakland City
Wood, Russell W.....Oakland City
Geller, Samuel .....Owensville

GIBSON COUNTY

(Continued)

Montgomery, James R...Owensville
Alexander, Harry H.....Princeton
Carpentier, Harry F.....Princeton
Folck, John K.....Princeton
Graves, Orville M.....Princeton
Hollingsworth, M. P. (H).Princeton
McCarty, Virgil .....Princeton
McElroy, Robert S.....Princeton
Miller, Charles A. (H)...Princeton
Peck, James F.....Princeton
Rhodes, Amos H.....Princeton
Strickland, Karl S.....Princeton
Weitzel, Roland .....Princeton

GRANT COUNTY

Holliday, L. D.....Fairmount
King, Dale S.....Fairmount
Seale, Joseph P.....Fairmount
Garrison, Leon J.....Gas City
Koontz, William A.....Gas City
Baskett, Russell J.....Jonesboro

Marion

Abell, Chas. F.
321 Marion Natl. Bk. Bldg.
Ayres, Wendell W...302 Glass Blk.
Bloom, Asa W.....724 W. Third
Boyer, Grace M..313 Iroquois Bldg.
Braunlin, Robert F.
718 Marion Nat. Bank Bldg.
Braunlin, William H.
718 Marion Nat. Bank Bldg.
Brown, Robert M.
522 Marion Nat. Bank Bldg.
Burge, A. D..204 Odd Fellows Bldg.
Daniels, Erle O.
708 Marion Nat. Bank Bldg.
Daniels, Geo. R.....324 Glass Blk.
Davis, Joseph B.
516 Marion Nat. Bank Bldg.
Davis, Merrill S.
516 Marion Nat. Bank Bldg.
Diamond, Leo L.
612 Marion Nat. Bank Bldg.
Dick, Fred.....Marion Gen. Hosp.
Eshleman, L. H. (H).2927 S. Wash.
Fisher, Henry.....1502 S. Wash.
Ganz, Max.....930 S. Adams
Ginsberg, S. T.....Veterans Hosp.
Huff, Asher D.....310 Glass Blk.
Hummel, Russel M.
317 Marion Nat. Bank Bldg.
Lavengood, R. W....511 Glass Blk.
Long, Max R.....803 S. Boots
McIlwain, Eleanor E....107 E. 31st
McIlwain, Robt. E.....107 E. 31st
Miller, H. Allison...321 Glass Blk.
Powell, J. Paxton...309 Glass Blk.
Powell, Nettie B. (H)..615 Whites
Renbarger, L. L....1531 W. Second
Rhorer, John G.....201 S. D St.
Sandy, Wm. A.....Veterans Hosp.
Simmons, Fredk. H.....113 W. 3rd
Skomp, C. E.....Marion Gen. Hosp.
Sullenger, A. A..Marion Gen. Hosp.
Warren, Carroll B...408 Glass Blk.
Weinberg, Samuel...318 Glass Blk.
Williams, C. L.....Veterans Hosp.
Young, Robt. G.....2927 S. Wash.

King, Peter C.....Swayzee
Taylor, Everett C.....Upland
Rifner, E. S.....Van Buren
List, Harold E.....Naval Air Sta., Glenview, Ill.
Davis, Richard.....Mayo Clinic, Rochester, Minn.

GREENE COUNTY

Graf, Jerome A.....Bloomfield
Mount, Mathias S.....Bloomfield
Turner, Harold B.....Bloomfield
Turner, Jack J.....Bloomfield
Porter, Carl M.....Jasonville
Rotman, Harry G.....Jasonville
Rotman, Sam I.....Jasonville
Bailey, Edwin B.....Linton
Broshears, Kenneth .....Linton
Craft, William F.....Linton
Porter, George C.....Linton
Raney, Ben B.....Linton
Woner, John W.....Linton
Manzie, Michael W.....Lyons
Simons, James (H).....Lyons
Hamilton, M. Luther....Newberry
Fender, Asa H.....Worthington
Moses, George E.....Worthington
Moses, Robert E.....Worthington

HAMILTON COUNTY

Hicks, Joseph (H).....Arcadia
Rodenbeck, Frank .....Arcadia
McDaniel, Franklin P.....Atlanta
Campbell, Sam W.....Carmel
Donahue, Claude M.....Carmel
Havens, Oscar .....Cicero
Ambrose, Jesse C.....Noblesville
Harris, Robert F.....Noblesville
Hash, John S.....Noblesville
Hooke, Samuel W.....Noblesville
Kraft, Haldon C.....Noblesville
Shanks, Ray .....Noblesville
Shonk, Harold W.....Noblesville
Southard, Carl B.....Noblesville
Thayer, Jos. O...R.R. 1, Noblesville
Griffith, James W.....Sheridan
Newby, Alonzo C.....Sheridan
Newby, Eugene .....Sheridan
Reck, John L.....Sheridan
Young, Edward M. (H)...Sheridan
Connoy, Andrew F.....Westfield
Connoy, Leo F.....Westfield
Tomlinson, C. H. (H)
Lake Forest, Ill.

HANCOCK COUNTY

Ferrell, Jesse E.....Fortville
Ferrell, Mars B.....Fortville
Manifold, Harold M.....Fortville
Navin, Hugh K.....Fortville
Allen, Joseph L. (H)....Greenfield
Endicott, Wayne .....Greenfield
Gibbs, Charles M. (H)...Greenfield
Gill, Dee D.....Greenfield
Heller, Oscar S. (H)....Greenfield
Kinneman, Robert E.....Greenfield
Rariden, Lawrence B....Greenfield
Woods, James R., Jr.....Greenfield
Larrabee, William H. (H)
New Palestine
Pierson, Thos. A....New Palestine
Kuhn, Robert W.....Wilkinson
Titus, Charles R. (H)...Wilkinson

HARRISON COUNTY

Amy, William E.....Corydon
Blessinger, Louis H.....Corydon
Dillman, Carl E.....Corydon
Baker, Guy D.....Crandall
Mathys, Alfred .....Mauckport
Glenn, Lafayette .....Ramsey

HENDRICKS COUNTY

Foltz, Lloyd E.....Brownsburg
Scudder, Arthur N.....Brownsburg
Ellett, John, Jr.....Coatesville
Frantz, Mount E.....Danville
Gibbs, Joseph W.....Danville
Huckleberry, Carl D.....Danville
Koch, Elmer L.....Danville
Price, Ernest H.....Danville
Terry, Lloyd .....Danville
Ellis, Lyman H.....Lizton
Wiseheart, O. H. (H).North Salem
Scamahorn, Malcolm O...Pittsboro
Scamahorn, Oscar T. ....Pittsboro
Stafford, James C..... .Plainfield
Stafford, William C.....Plainfield

HENRY COUNTY

Dreyer, Ralph W.....Knightstown
Walker, Jack .....Knightstown
Scheetz, Marion R.....Lewisville
Dragoo, Farrol .....Middletown
Hammer, Jay W.....Middletown
Stauffer, George E.....Mooreland

New Castle

Amos, Robert L.....1219½ Race St.
Blaize, Joshua A.
Ind. Village for Epileptics
Bledsoe, James G.....319 S. 14th
Canaday, Clifford E...1411 Church
Coats, Edwin A.
Ind. Village for Epileptics
Fisher, John E.....409 Burr Bldg.
Foster, Ray T.....Chrysler Corp.
Heilman, William C...1319 Church
Hill, Kenneth G.....1319 Church
Iterman, George E....1319 Church
Kennedy, Walter U.....214 S. 14th
Life, Homer L.....1015 Broad
McDonald, Frank C....106 N. Main
McElroy, James S.....1319 Church
Smith, Robert A.....108 N. Main
Stout, Walter M.....1319 Church
Thorne, Charles E.....200 N. 12th
Tully, John A.....502 S. Main
Van Nuys, W. C.
Ind. Village for Epileptics
Wiggins, Dulania S. (H)
1222½ Race
Wiggins, George.....1222½ Race

Wilson, Ralph (H).....Shirley

HOWARD COUNTY

Denton, Larkin D.....Greentown
Shoup, Homer B.....Greentown

Kokomo

Boughman, Joe D.
322 Armstrong-Landon Bldg.
Bowers, C. C.....210 W. Mulberry

HOWARD COUNTY

(Kokomo—Continued)

Bowers, Garvey B. 210 W. Mulberry
Bowers, John A. . . 210 W. Mulberry
Bruegge, Theodore J.
630 Armstrong-Landon Bldg.
Clarke, Elton R. . . . . 400½ N. Main
Conley, Thomas M.
520 Union Bank Bldg.
Craig, Reuben A.
608 Armstrong-Landon Bldg.
Cuthbert, Fredk. S. 211 E. Jefferson
Ferry, P. W. . . 406 Union Bk. Bldg.
Good, Richard P.
308 Armstrong-Landon Bldg.
Halfast, Richd. W. 314 E. Mulberry
Harrison, W. H. (H). 318½ N. Main
Hutto, William H.
408 Armstrong-Landon Bldg.
Jewell, George M.
508 Armstrong-Landon Bldg.
Knepple, LaMarr R. (H)
325½ N. Main
Kratzer, Eugene F. . 320 W. Walnut
Lung, Bruce D. 410 Union Bk. Bldg.
McIndoo, Ralph E. . . 304 W. Walnut
Meiner, Joseph A. . . . . 911 S. Main
Morrison, William R.
504 Union Bank Bldg.
Murray, Ernest C. . 207 E. Mulberry
Paris, Durward W.
614 Armstrong-Landon Bldg.
Phares, Robt. W. . . 905 W. Mulberry
Ramey, John W. . . . . 107½ S. Union
Rhorer, Herbt. M. . 210 W. Mulberry
Schuler, Russell P. . . . 200½ N. Main
Schwartz, Frederick C.
518 Armstrong-Landon Bldg.
Scott, Russell F. . . . Union Bk. Bldg.
Shenk, Earl M. . . . . 208½ N. Main
Smith, Gloster J. . 105½ E. Sycamore
Sorenson, Raymond
522 Armstrong-Landon Bldg.
Spangler, Jesse S. . . . 215 E. Taylor

Evans, Robert M. . . . . Russiaville

HUNTINGTON COUNTY

Huntington

Brubaker, Harold S. 42 W. Park Dr.
Casey, Stanley M. . . . 408 E. Market
Clunie, Wm. A. . . . . 502 N. Jefferson
Cope, Stanton E. . 1022 N. Jefferson
Erehart, Mark G. . . . 232 W. Market
Eviston, John B. . . . . 34 E. Wash.
Galbreath, Russell S. . . 16 W. Wash.
Gray, Paul M. . . . . 340 E. Market
Grayston, Fred W. (H)
708 N. Jefferson
Grayston, W. S. . . . . 303 E. Market
James, Thomas, Jr. . . 48 E. Franklin
Johnston, Robt. G. . . . 339 E. Market
Marks, Howard H. . . . . 248 W. Park
Meiser, Robt. D. . . 612 N. Jefferson
Mitman, Floyd B. . . . . 210 W. Park
Nie, Grover M. . . . . 220 W. Park Dr.
Omstead, T. W. . 244 E. Washington
Ware, James R. . . . . 48 E. Franklin

Wimmer, George G. . . . . Mt. Etna
Bennett, J. B. . . . . Warren
Black, C. S. . . . . Warren
Bonifield, Harold F. . . . . Warren
Smith, Lucian . . . . . Warren

JACKSON COUNTY

Cummings, David J. . . Brownstown
Gillespie, Garland R. . . Brownstown
Shields, Jack E. . . . . Brownstown
Adair, William K. . . . . Crothersville
Bard, Frank B. . . . . Crothersville
Conner, Thos. E. (H) . . . . Freetown
Black, Joe M. . . . . Seymour
Day, William D. C. . . . . Seymour
Elsner, Lawrence W. . . . . Seymour
Gillespie, Charles E. . . . . Seymour
Graessle, Harold P. . . . . Seymour
Kamman, Geo. H. (H) . . . . Seymour
Martin, Guy . . . . . Seymour
Miller, Harold E. . . . . Seymour
Osterman, Louis H. . . . . Seymour
Ripley, John W. . . . . Seymour
Shortridge, Wilbur H. . . . . Seymour
Wright, Elmer D. . . . . Seymour

JASPER-NEWTON COUNTIES

Pippenger, Wayne G. . . . . Brook
Ockermann, Kenneth R. . . DeMotte
Openshaw, James F. . . . . Goodland
Smith, Marsh H. . . . . Goodland
Mathews, Wilbur C. . . . . Kentland
Roesch, Ryland . . . . . Kentland
VanKirk, George H. . . . . Kentland
Yegerlehner, Roscoe S. . . . Kentland
Larrison, Glenn D. . . . . Morocco
Schantz, Richard . . . . . Remington
Sink, Frank G. . . . . Remington
Beaver, Ernest . . . . . Rensselaer
English, Harry E. . . . . Rensselaer
Johnson, Cecil E. . . . . Rensselaer
Kresler, Leon . . . . . Rensselaer
O'Neill, Martin . . . . . Rensselaer
Gwin, Merle D. . . 2111 Regatta Ave.,
Miami Beach, Fla.

JAY COUNTY

Garber, Edwin C. . . . . Dunkirk
Hall, Emory H. . . . . Dunkirk
Heller, Nelson L. R. . . . . Dunkirk
Pruitt, Edward . . . . . Dunkirk
Hiestand, Harley J. . . . . Pennville
Badders, Ara C. . . . . Portland
Cring, George V. . . . . Portland
Dulin, Basil . . . . . Portland
Engle, John M. . . . . Portland
Fitzpatrick, James . . . . . Portland
Hammond, Stanley M. . . . . Portland
Keeling, Forrest E. . . . . Portland
Lyon, Florence . . . . . Portland
Moran, Mark M. . . . . Portland
Morrison, George G. . . . . Portland
Schwartz, Wm. D. (H) . . . Portland
Spahr, Donald E. . . . . Portland
Hanna, Duke . . . . . Redkey
Lansford, John . . . . . Redkey
Kidder, John J. (H) . . . . Salamonia
Streib, Frederick
Chula Vista, Calif.

JEFFERSON COUNTY

Henning, Carl . . . . . Hanover

Madison

Beetem, Luther F. . . . . 425 W. Main
Childs, A. G. W. (H) . . 412 E. Main
Childs, Wallace E. . . . . 420 Elm
Jolly, Lewis E. . . . . Madison
May, George A. . . . . 426 E. Main
Petway, Allen P. . . . . 426 E. Main
Prenatt, Francis
Madison State Hospital
Sharman, E. J. . . . . 610 E. Second
Shuck, Wm. A. . . Odd Fellows Bldg.
Turner, Anna L. . . . . 104 E. Third
Turner, Oscar A. . . . . 104 E. Third
Whitsitt, Schuyler A. (H)
718 W. Main
Zink, Robert O. . . . . 106 E. Third

JENNINGS COUNTY

Heath, Rebecca H. . . . . Butlerville
Robertson, David W. (H) . . Deputy
Green, John H. . . . . North Vernon
Grossman, Wm. L. . . . North Vernon
Matthews, Dennis W. North Vernon
Stemm, Wm. H. (H). North Vernon
Thayer, Benet W. . . . North Vernon

JOHNSON COUNTY

Lutes, D. L. . . . . Edinburg
Deppe, Charles F. . . . . Franklin
Eaton, Lyman D. . . . . Franklin
Ferrara, Joseph F. . . . . Franklin
Jones, Charles A. . . . . Franklin
Manuel, Donald . . . . . Franklin
Murphy, George M. . . . . Franklin
Murphy, Harry E. . . . . Franklin
Portteus, Walter L. . . . . Franklin
Province, Oran A. . . . . Franklin
Province, William D. . . . . Franklin
Records, Arthur W. . . . . Franklin
Wilson, Russell C. . . . . Franklin
Barnes, Helen Beall . . . . Greenwood
Brown, George E. . . . . Greenwood
Sheek, Kenneth I. . . . . Greenwood
Tiley, George A. . . . . Greenwood
Woodcock, Charles E. . . . Greenwood
Machledt, John H. . . . . Whiteland

KNOX COUNTY

Byrne, Robert J. . . . . Bicknell
Donham, William L. . . . . Bicknell
Fox, Richard H. . . . . Bicknell
Little, William J. . . . . Bicknell
Meade, Walter W. . . . . Bicknell
Wilson, Guy H. . . . . Bicknell
Scudder, John A. . . . . Edwardsport
Raper, Geo. T. . . . . Freelandville
Hodges, William A. . . . . Oaktown
Springstun, George H. . . . Oaktown
Pahmeier, John W. . . . . Sandborn

Vincennes

Albrecht, Joseph R.
200 Harrison Bank Bldg.
Anderson, Richard M.
301 LaPlante Bldg.
Arbogast, Paul B. . . . . 915 Main
Bailey, W. A. (H) . . . 516 Busseron
Beckes, Ellsworth W. 603 Busseron
Beckes, N. E. (H) . . . 414 Broadway
Boyd, Claudius L. . . . 114 N. Fourth

KNOX COUNTY

(Vincennes—Continued)

Chattin, Herbert O.....729 Main
Coffel, Melvin H.
424 LaPlante Bldg.
Curtner, Myron L.....222 N. Sixth
Edwards, Edward T., Jr.
1045 Washington Ave.
Ewing, Nathaniel D....14 N. Third
Fox, Maurice S.
223-30 American Nat. Bk. Bldg.
Green, Carl L.....1004 Main
Hoffman, Doris.....324 Vigo
Humphreys, Joe E....217 N. Third
Johnson, Morris H. C....9 N. Fifth
McCormick, Hubert D.
325 LaPlante Bldg.
McDowell, Mordecai M.
223 American Bank Bldg.
McMahan, Virgil C.
410 LaPlante Bldg.
Meyer, Raymond C. Hillcrest Hosp.
Moore, Robert G.....21 N. Third
Nance, William K.....324 Vigo
Reilly, James F.....418½ Main
Richards, D. H. (H)
215 American Nat. Bk. Bldg.
Schulze, William
223 American Bank Bldg.
Shaffer, Kenneth L.
404 LaPlante Bldg.
Smith, Ralph O.....12 S. Fourth
Smith, Saml. J. 301 LaPlante Bldg.
Spencer, Frederic
421 LaPlante Bldg.
Welch, Norbert M.
410 LaPlante Bldg.

Pierce, Gene S.....Wheatland

KOSCIUSKO COUNTY

McIlroy, Richard J.....Claypool
Leasure, Kenneth.....Etna Green
Thomas, Charles E. (H)..Leesburg
Urschel, Dan .....Mentone
Herring, George N.....Pierceton
Schuldt, T. S.....Pierceton
King, James R.....Silver Lake
Clark, Fred .....Syracuse
Fosbrink, E. L.....Syracuse
Hammond, George M.....Warsaw
Richer, Orville H.....Warsaw
Schlemmer, George H.....Warsaw
Thomas, Everett W.....Warsaw

LAGRANGE COUNTY

Wade, Alfred A.....Howe
Benedict, Charles D.....LaGrange
Flannigan, Harley F.....LaGrange
Schulz, Clarence H.....LaGrange
Weir, Dale .....LaGrange
Robertson, Wm. .....Shipshewana
Hildebrand, William O.....Topeka
Lehman, Kenneth M.....Topeka

LAKE COUNTY

Bolin, John T.....Cedar Lake
King, Robert W.....Cedar Lake

Crown Point

Becker, Philip H.
Lake County T. B. Sanitarium
Birdzell, John P. ....124 N. Main
Gray, Daniel E.....235 S. Main
Horst, William N.....138 S. Main
Iddings, John W.....124 N. Main
Klaus, J. M. .....224 S. Court
Monroe, F. Bruce.....Crown Point
Seyler, Anna G.
Lake County T. B. Sanitarium
Steele, Everett B.....124 N. Main
Weis, William D. (H) Court House

Adler, Edmund R.....Dyer

East Chicago

Arnold, M. F.
4614 Indianapolis Blvd.
Beilke, Clifford A...815 W. Chicago
Benchick, Frank A.
4712 Magoun Ave.
Benedek, Tibor....3406 Guthrie St.
Bonaventura, Angelo P.
3701 Main St.
Boyd, Chas. S..4739 Melville Ave.
Boys, Fay F...722 W. Chicago Ave.
Braun, Benjamin D.
St. Catherine's Hospital
Broomes, Edw. L.....3924 Deal St.
Callahan, Richard H..3502 Main St.
Campagna, Ettro A...3406 Guthrie
Carleton, Edward H.
Inland Steel Co.
Cole, Arthur V....3406 Guthrie St.
Cotter, Edward R.
720 W. Chicago Ave.
Dainko, Alfred J.
823 W. Chicago Ave.
Ernst, H. C...720 W. Chicago Ave.
Fleischer, Jacob C....3406 Guthrie
Govorchin, Alexander
724 W. Chicago Ave.
Grosso, William G.
722 W. Chicago Ave.
Gustaitis, John W.
St. Catherine's Hospital
Hamilton, Robert C.
2602 E. 140th Place
Hayes, Jesse D.....4742 Melville
Johns, David R.
724 W. Chicago Ave.
Komoroske, John E.
723 E. Chicago Ave.
Kopanko, Bernard F.
823 W. Chicago Ave.
Levin, Eli .....3700 Main St.
McGuire, Desmond F.
3429 Michigan Ave.
Marks, Ora L..815 W. Chicago Ave.
Nakadate, Katsumi J.
815 W. Chicago Ave.
Niblick, James S.....3406 Guthrie
Nicosia, John B.....3701 Main St.
O'Connor, James J...3701 Main St.
Petronella, Samuel J.
4614 Indianapolis Blvd.
Ramker, Daniel T.
3406 Guthrie Ave.
Shapiro, Joseph .....3700 Main St.
Shulruff, H. I.....3701 Main St.
Teegarden, Joseph A., Jr.
3336 Michigan Ave.
Teegarden, Joseph A.
3336 Michigan Ave.
Trepagnier, Francis B.
3616 Main St.
Vore, Hugh A...4231 Magoun Ave.

Gary

Almquist, Carl O.....504 Broadway
Anthoulis, Geo. D...1206 Broadway
Baitinger, Herbert M.
504 Broadway
Behn, Walter M.....738 Broadway
Bendler, Carl H.....738 Broadway
Bills, Robert N.....504 Broadway
Boardman, Carl ....504 Broadway
Brady, Samuel G. ...765 Broadway
Brandman, Harry...504 Broadway
Brown, David B. ... 504 Broadway
Brown, Leo R.....3855 Broadway
Bullard, Mattie J...524 Garfield St.
Burcham, James B...738 Broadway
Carbone, Joseph A. 504 Broadway
Carmody, Raymond F.
504 Broadway
Chevigny, Julius J.. 504 Broadway
Cooper, Leo K.....504 Broadway
Cotterman, Vernon L.
3811 Washington St.
Crossland, Steward H.
Methodist Hospital
Darling, Dorothy.1600 W. 6th Ave.
Davis, Neal, Box 928, Ogden Dunes
DeLong, Charles A. (H)
583 Broadway
Dian, August J. ....729 Broadway
Dian, Julia .....729 Broadway
Donchess, Joseph C..215 Broadway
Doty, James R.....504 Broadway
Duncan, John S....2165 W. 11th St.
Elliott, Ralph A.....504 Broadway
English, Hubert M...673 Broadway
Fischer, Burnell.1070 Warren Ave.
Galante, Vincent J..Mercy Hospital
Gannon, G. W.....602 Broadway
Goldberg, Harold B..515 Broadway
Goldstone, Adolph ..757 Broadway
Goldstone, Joseph ..757 Broadway
Goldstone, S. R.....757 Broadway
Gorton, Mary L.....400 Broadway
Grant, Benjamin ..1706 Broadway
Gutierrez, F. A.....504 Broadway
Harris, Donald N.....4813 Madison
Hinkson, Geo. D....1606 Broadway
Hodurski, Zigfield ..4319 Broadway
Johnson, Lonnie B.
123 W. 21st St.
Kahan, Harry L.....738 Broadway
Kendrick, Frank J...504 Broadway
Kobrin, Meyer W....729 Broadway
Kolettis, George J...860 Broadway
Kopcha, Joseph E....504 Broadway
Korn, Jerome M.....742 Broadway
Kron, R. Vincent .....3538 Central
Lebioda, Henry S...8 W. Ridge Rd.
Lorenty, Thaddeus B.
738 Broadway
Lovell, Martin H...1606 Broadway
Lutz, Georgianna....504 Broadway
McMichael, F. J. ....504 Broadway
Majsterek, Stanley L.
1902 W. 11th Ave.
Marcus, Morris C...738 Broadway
Mather, J. W.....3543 Central,
East Gary
May, Richard M.....583 Broadway
Minczewski, Richard C.
504 Broadway

LAKE COUNTY

(Gary—Continued)

Molengraft, Cornelius J. 527 Broadway
Moore, E. Gregory .1901 Broadway
Moore, Edwin G....1606 Broadway
Morris, Hyman ....17 W. 8th Ave.
Nelson, Walfred R..550 S. Lake St.
Nesbit, Otis B. (H).444 Jackson St.
Neuwelt, Frank ....504 Broadway
Ornelas, Jos. P.....607 Broadway
Palmer, Russell H. 2006 W. 4th Place
Parker, Harry C.....673 Broadway
Parratt, Louis W. .100 E. 7th Ave.
Reynolds, James S...504 Broadway
Richter, Samuel ....738 Broadway
Robinson, Walter K..504 Broadway
Rosenbloom, Philip J. 504 Broadway
Rubin, Milton R. ....504 Broadway
Rubin, Simon S. ....504 Broadway
Ryan, Hubert J. ....504 Broadway
Sagel, Jacob .....504 Broadway
Sala, Joseph J. .....504 Broadway
Sala, Walter R. .....504 Broadway
Schaible, Ernest L...738 Broadway
Senese, Thos. J.....504 Broadway
Shellhouse, Michael 3811 Washington St.
Skeen, Earl D. .....504 Broadway
Slama, Earl D. ....3624 Buchanan
Spellman, Frank W....564 S. Lake
Stimson, H. R.....504 Broadway
Stoycoff, Christo M..844 Broadway
Templin, David B....504 Broadway
Trinosky, Donald L..504 Broadway
Verplank, Grover L..527 Broadway
Weiskopf, Henry S...504 Broadway
Wharton, Russell O..673 Broadway
White, W. J. (H)....790 Broadway
Wicks, Orlando C. (H) 560 Van Buren
Williams, Alexander S. 504 W. 25th St.
Wimmer, Robert N.....9 W. 6th St.
Yarrington, Charles W. 607 Broadway
Yocum, Paul S. .....738 Broadway
Yocum, Wm. S. .....583 Broadway
Young, George M...3776 Broadway

Hazinski, R. T. .....Griffith
Lundeberg, Ralph A.....Griffith
Malmstone, F. A.....Griffith
Siekierski, Joseph M.....Griffith

Hammond

Allegretti, Michael L. 5404 Hohman Ave.
Arbeiter, Herbert I. 5231 Hohman Ave.
Arrowsmith, James L. 5231 Hohman Ave.
Beconovich, Robt.....839 169th St.
Brown, Stanley L. 6550 Hohman Ave.
Carlo, Joseph F. 5305 Hohman Ave.
Chidlaw, B. W...5141 Hohman Ave.
Clancy, James F. 5231 Hohman Ave.
Cook, George M. 5231 Hohman Ave.
Dassel, Paul Milton 6744 Hohman Ave.
Davis, Alice L...5116 Hohman Ave.
Detrick, Herbert W. 5231 Hohman Ave.
Eggers, Ernest L. 5141 Hohman Ave.
Eggers, Henry W. 5231 Hohman Ave.
Egnatz, Nicholas...522½ State S.t
Elledge, Ray....5231 Hohman Ave.
Friedman, Isadore E. 5248 Hohman Ave.
Gevirtz, Milton B. 5246 Hohman Ave.
Hack, Edmund C. 5217 Hohman Ave.
Hansen, Arthur H. 5252 Hohman Ave.
Hickman, A. L..5248 Hohman Ave.
Hofmann, Andrew...408 State St.
Hopkins, J. R...5217 Hohman Ave.
Howard, William H. 5231 Hohman Ave.
Husted, Robert G. 5248 Hohman Ave.
Jones, Eli S.....5231 Hohman Ave.
Kolanko, Leon A. 5435½ Hohman Ave.
Koransky, David S. 5231 Hohman Ave.
Kretsch, R. W.....5435½ Hohman
Kuhn, Hedwig S...112 Rimbach St.
Kuhn, Hugh A.....112 Rimbach St.
Larrabee, James F. 5245 Hohman Ave.
McLean, James S....522½ State St.
Marcus, Emanuel 5252 Hohman Ave.
Marks, Salvo .....409 Yale Bldg.
Matthews, Charles B. (H) 5252 Hohman Ave.
Modjeski, Joseph R. 5451½ Hohman Ave.
Modjeski, Raymond J. 5231 Hohman Ave.
Morrison, Lindsey (H) 109 Rimbach St.
Murphy, Joseph F., Jr. 139 Rimbach St.
Musacchio, Frederick A. 330 City Hall
Neal, Leonard W. 5252 Hohman Ave.
Nelson, Richard B. 5618 Calumet Ave.
Nichols, William E. (H) 15 Warren St.
Nodinger, Louis.....540 165th St.
Panares, Solomon V. 5434 Hohman Ave.
Paul, William Thomas F. 5434 Hohman Ave.
Pilot, Jean .....5231 Hohman Ave.
Premuda, F. F..6727 Kennedy Ave.
Rauschenbach, Charles W. 5245 Hohman Ave.
Rawlins, Carolyn M.....614 173 St.
Remich, Antone C..137 Rimbach St.
Rendel, Donald T. 5231 Hohman Ave.
Rhind, A. W....5145 Hohman Ave.
Rosevear, Henry S. 5231 Hohman Ave.
Row, Perrie Q...5231 Hohman Ave.
Rudolph, Franklin G. 5231 Hohman Ave.
Schlesinger, Daniel J. 6010 Columbia
Schlesinger, Jacob 6010 Columbia Ave.
Shanklin, E. M..5141 Hohman Ave.
Sosson, Edward .....112 Rimbach
Stern, Samuel L. 5142 Hohman Ave.
Tilka, Edward ..5231 Hohman Ave.
Zeman, Theodore C. 112 W. Rimbach St.

Acos, James C. 2809 Highway Ave., Highland
Markey, Richard J. P. 2805 Highway Ave., Highland
Sroka, Stanley J. 8606 Kennedy Ave., Highland
Dupes, Lowell E.....Hobart
Friedrich, Louis M. (H)....Hobart
Markle, Joseph G. .....Hobart
Pike, Warren H. .....Hobart
Reed, John .....Hobart
Storer, W. R. .....Hobart
Teplinsky, Louis L.....Munster

Whiting

Bechtol, Lavon D. 1902 Indianapolis Blvd.
Ferry, John 1902 Indianapolis Blvd.
Frankowski, Clementine E. 1907 New York Ave.
Jones, Clifford M. 1902 Indianapolis Blvd.
Kudele, Louis T.....1321 119th St.
LaFollette, Forrest R. 1900 Indianapolis Blvd.
Marshall, Millard R. 1900 Indianapolis Blvd.
McCarthy, Jeremiah A. 1341 E. 119th St.
Rudser, Donald H. 1902 Indianapolis Blvd.
Silvian, Harry A....1400 119th St.
Smith, Theodore J. 1902 Indianapolis Blvd.
Stecy, Peter 1902 Indianapolis Blvd.
Thegze, G. A. .....1344 119th St.
Troy, Jack M. 1900 Indianapolis Blvd.
Walker, Adolph P. 1648 Calumet Ave.
Weinberg, B. A.....1348 119th St.

Beam, Vernon B. 3235 N. Schultz Dr., Lansing, Ill.
Forster, Neslen K. 1339 N. Capri Drive Pacific Palisades, Calif.
Holmes, George W. 340 W. Barry Ave., Chicago, Ill.
Kobrak, H. G.....950 E. 59th St., Chicago 31, Ill.
Weinland, Albert S. 8025 S. Paxton St., Chicago, Ill.
Kenney, Francis D. 1427 Damon Ct., Rochester, Minn.
Pettibone, Claude R. 22 University Dr., East Lansing, Mich.

LAKE COUNTY

(Continued)

Tyrrell, Thomas C.
704 Wentworth Ave.,
Calumet City, Ill.

LAPORTE COUNTY

Oak, David, Jr. .....Hanna
Oak, David D. .....LaCrosse

LaPorte

Carter, Fred S.....402 E. Jefferson
Cartwright, Jack D.
806 Madison St.
Elshout, Clem H..1004 Indiana Ave.
Fargher, Robert A.
811 Jefferson Ave.
Farnsworth, Samuel A.
702½ Lincoln Way
Fischer, Carlton N.
1001 Maple Ave.
Jones, John C.....Monroe Apts.
Jones, Robert B.
808 Michigan Avenue
Kelly, Jon N....704 Jefferson Ave.
Kelsey, Robert M...702 Maple Ave.
Kepler, Robert W..708 Harrison St.
Kistler, James J....911 Maple Ave.
Laramore, Ward ..911 Maple Ave.
Larson, G. O. ....809 Jefferson St.
Linn, Elbert E....809 Jefferson St.
Martin, William B.
812 Michigan Ave.
Morgan, Samuel P.
810 Michigan Ave.
Muhleman, C. E...901 Indiana Ave.
Przednowek, Adolph C.
909 Madison St.
Richter, John C. 808 Michigan Ave.
Ross, Wilbur W.....P. O. Box 102
Simon, Arthur R...806 Maple Ave.
Von Asch, George..912 Monroe St.
Wilcox, Robert F...808 Maple Ave.

Michigan City

Armstrong, Thomas D.
113 E. Ninth St.
Baker, Warren..427 Warren Bldg.
Bankoff, Milton L....123 E. 5th St.
Bernoske, Daniel G....731 Pine St.
Brooks, Harry L.....123 E. 5th St.
Burris, Floyd L.....731 Spring St.
Carlson, Norman R...229 E. 5th St.
Donovan, Stephen J.
916 Washington St.
Fargher, Francis M.
723 Franklin St.
Feerer, Donald.117 W. Seventh St.
Flaherty, Walter T.
1016 Washington St.
Gardner, Melvin D.
801 Washington St.
Gardner, Russell A.
801 Washington St.
Gilmore, Russell A.
301 Warren Bldg.
Henderson, N. C.
622½ Franklin St.
Hillenbrand, Charles
128 W. Tenth St.
Jones, King Solomon
328½ Franklin St.
Kemp, John T. .....122 E. 7th St.
Kerrigan, Robert L.
916 Washington St.
Kling, Victor F...507 Warren Bldg.
Kohrman, Benjamin M.
123 E. Fifth St.
Krieger, George M.
701 Washington St.
Kubik, Francis J.....201 E. 8th St.
Lava, Irving M.....125 E. 5th St.
Meyer, Milo G..801 Washington St.
Piazza, Leonard F.
404 Warren Bldg.
Plank, C. Robert...732 E. Pine St.
Reed, Ann M.....123 E. Fifth St.
Reed, Nelle .....501 Pine St.
Robrock, Lawrence M.
315 Warren Bldg.
Spinning, A. L. (H)
130 Superior St.
Straus, David C....123 E. Fifth St.
Walters, William H...Warren Bldg.
Weeks, Patrick H.....Box 41

Weinstock, Adolph.Rolling Prairie
Moosey, Louis .....Union Mills
Hetman, Mitchell J.....Westville
Benz, Owen .....Wanatah
Birge, Jackson P.
219 N. Huron, Ypsilanti, Mich.
Saide, Robert A.
12023 San Vincente Blvd.,
W. Los Angeles, Calif.

LAWRENCE COUNTY

Bedford

Allen, L. Howard
305 Citizens Nat. Bank Bldg.
Austin, Richard P.
209 Citizens Nat. Bank Bldg.
Bridwell, Edgar .....1317 L St.
Dusard, Joseph C.
304 Citizens Nat. Bank Bldg.
Edmonds, Kendrick ..1303 15th St.
Emery, Charles B.....1027 15th St.
Emery, Charles H. (H)
1027 15th St.
Fountaine, Thomas J.
200 Citizens Nat. Bank Bldg.
Hammel, Howard T.
Citizens Nat. Bank Bldg.
Kerr, Donald M. .....1317 L St.
Martin, Frank D.....1501 I St.
Meyer, Orlando L.....1317 L St.
Newland, Arthur E...1112 15th St.
Pearson, John R.
Citizens Nat. Bank Bldg.
Ragsdale, Harrison C.
200 Citizens Nat. Bank Bldg.
Robertson, Moorman O.
400 Citizens Nat. Bank Bldg.
Scherschel, John P.....1711 H St.
Smallwood, Robert B.
204 Citizens Nat. Bank Bldg.
Speheger, Benjamin A...1317 L St.
Wohlfeld, Julius B....1124 16th St.
Woolery, Richard
207 Citizens Nat. Bank Bldg.
Wynne, Roland E.
301 Citizens Nat. Bank Bldg.

Hamilton, James R.....Mitchell
Oswalt, James Telfer.....Mitchell
Strickland, William B.....Mitchell
Dollens, Claude .....Oolitic

MADISON COUNTY

Carpenter, John L.....Alexandria
Gaunt, Everett W.....Alexandria
Keller, Frank G. (H)...Alexandria
Overpeck, George H....Alexandria
Shafer, Richard H.....Alexandria

Anderson

Aagesen, Walter J.
615 Citizens Bank Bldg.
Armington, Charles L.
657 Anderson Bank Bldg.
Armington, John C.
657 Anderson Bk. Bldg.
Armington, Robert L.
318 Citizens Bank Bldg.
Austin, Maynard A.
238 W. 12th St.
Ayres, Kenneth D.
704 Anderson Bank Bldg.
Baughn, William L.
1635 W. 12th St.
Benoit, Merrill P.....Delco Remy
Blassaras, Chris....2005 Broadway
Brauchla, Carl H...117 W. 17th St.
Brock, Earl E.....931 Meridian St.
Buckles, David L..St. John's Hosp.
Collins, Albert W. (H)
1834 Broadway
Conrad, Ernest M. (H)
2124 Meridian
Coy, Francis Matthew
534 Citizens Bank Bldg.
Dixon, Rex W.....934 W. 8th St.
Doenges, James L.
631 Citizens Bank Bldg.
Drake, John C.
604 Anderson Bank Bldg.
Ellis, Seth W.....335 W. 5th St.
Elsten, Aubrey W.
704 Anderson Bank Bldg.
Erehart, Archie D.
714 Anderson Bank Bldg.
Fisher, Warren E.
St. John's Hospital
Gante, Henry W.
1110 N. Meridian St.
Guthrie, Francis C.
412 Anderson Bank Bldg.
Hart, William D.
515 Citizens Bank Bldg.
Hensler, Benton M..12 W. 29th St.
Jarrett, Paul E.
315 Citizens Bank Bldg.
Jones, Albert T.
712 Anderson Bank Bldg.
Jones, Horace E.
1110 Meridian St.
Kelly, Wendell C.....704 E. 8th St.
King, Bernard A.
1110 Meridian St.
King, Joseph W.
1110 N. Meridian St.
Kopp, Otis A..1110 N. Meridian St.
Lamey, James L.
511 Citizens Bank Bldg.
Lamey, Paul T.
423 Citizens Bank Bldg.
Larmore, Joseph L.
712 Anderson Bank Bldg.
Larmore, Sarah M. .....R. R. 8

MADISON COUNTY

(Anderson—Continued)

Litzenberger, Sam W.
622 Citizens Bank Bldg.
Long, Paul L.
710 Anderson Bank Bldg.
McDonald, Vergil G.
1110 Meridian St.
Meister, Doris Citizens Bank Bldg.
Metcalf, George B.
931 Meridian St.
Miley, Weir M.....718 Madison St.
Morris, Robert A....2003 Meridian
Neale, Alfred
234 Citizens Bank Bldg.
Nelson, Paul L....330 West 7th St.
Nesbit, Leonard L.
415 Citizens Bank Bldg.
Patterson, William K.
St. John's Hospital
Polhemus, Warren C.
1803 Pearl St.
Quickel, Daniel S. (H)
5 Griffith Bldg.
Reed, Roger R.
412 Anderson Bank Bldg.
Rosenbaum, Lloyd E.
647 Citizens Bank Bldg.
Ross, Guy E.
661 Citizens Bank Bldg.
Rozelle, Clarence V.
615 Citizens Bank Bldg.
Sharp, William L.
449 Citizens Bank Bldg.
Stamper, Joseph H...R. R. 7, Bx. 47
Swan, Richard C.....Delco Remy
Webb, Harry .....2419 Main St.
Wilder, Gordon B.
612 Anderson Bank Bldg.
Wilkinson, Roger L...4 E. 38th St.
Williams, Francis ....1132 Central
Williams, Robert H.
1132 Central Ave.
Willson, Canby L.
2003 Meridian St.
Wright, Cecil S.
523 Citizens Bank Bldg.
York, Arthur F.
602 Citizens Bank Bldg.
Zierer, R. O.....931 Meridian

Elwood

Cullipher, Jeremiah E. (H)
903 Main St.
Drake, M. C.....1201 Main St.
Hanson, Martin F.
1102 S. Anderson St.
Hoppenrath, William H. (H)
1300 Main St.
Laudeman, Walter A..1309 S. A St.
Ploughe, Monroe L. (H)
1709 S. D St.
Ploughe, Ralph R..517 S. Anderson

Bishop, Harry A.....Frankton
Rinne, John I. .....Lapel
Bridges, William L.....Markleville
McLaughlin, Calvin P....Pendleton
Sisson, Helen M. .....Pendleton
Irwin, Seth .....Summitville
VanNess, William C...Summitville
McVaugh, Charles C.
4503 N. Winchester, Chicago, Ill.

MARION COUNTY

Fisher, Gerald E. .....Acton
Berger, Morley
902 Main St., Beech Grove
Kim, Young D.
136 N. 17th St., Beech Grove
Ramage, Walter F.
244 S. First St., Beech Grove
Rhea, James C.
801 Main St., Beech Grove
Hade, F. L. .....Bridgeport
Zerfas, Leon G. ....R. R. 1. Camby
Garrison, James L. ...Cumberland

Indianapolis

A

Abreu, Benedict E.
1200 Madison (6)
Adkins, Harold C...409 E. 30th (5)
Adkins, Onan C.
3635 Watson Rd. (5)
Adney, Frank B., Jr.
General Hospital (7)
Albertson, Frank P.
5304 W. Washington (21)
Aldrich, Harry D.
401 Hume Mansur Bldg. (4)
Aldrich, Howard
4316 E. Washington (1)
Alexander, Ezra D.
617 Indiana, No. 304 (2)
Alvis, Edmond O.
320 Hume Mansur Bldg. (4)
Anderson, Ralph J.
718 Hume Mansur Bldg. (4)
Anderson, Wendell C.
1330 W. Michigan (7)
Appel, Richard H.
603 Hume Mansur Bldg. (4)
Arbogast, J. L.
I.U. Med. Center (7)
Arbuckle, Russell
615 Hume Mansur Bldg. (4)
Arbuckle, Wm. E.....1156 Lee (21)
Arnold, Aaron L.
607 E. Maple Rd. (5)
Arnold, Robert D..3419 E. 10th (1)
Aronson, Sidney S.
618 Hume Mansur Bldg. (4)

B

Bachmann, Arnold J.
207 W. 34th (8)
Bahr, Max A. (H)
Central State Hospital (22)
Bakemeier, Otto H.
5503 E. Washington (19)
Balch, James F.
709 Hume Mansur Bldg. (4)
Ball, Joseph E.....5039 E. 10th (1)
Banister, Revel F..2958 Central (5)
Banks, Horace M.
Methodist Hosp. (7)
Barry, M. Joseph, Sr.
508-509 Doctors' Bldg. (4)
Barry, Maurice J., Jr.
I. U. Medical Center (7)
Bartley, Max D.
803 Hume Mansur Bldg. (4)
Batman, Gordon W.
723 Hume Mansur Bldg. (4)
Battersby, J. Stanley
I. U. Medical Center (7)
Batties, Paul A.
308 Walker Bldg. (2)
Bauer, Thomas B.
1015 Hume Mansur Bldg. (4)
Baum, Harry
VA Regional Office (4)
Beach, Robert R...2630 E. 10th (1)
Bean, Joseph S...General Hosp. (7)
Beasley, Thomas J.
112 Berkley Rd. 8)
Beaver, Howard W.
11 E. Raymond (25)
Beck, Evart M.
633 E. Maple Rd. (5)
Beckman, Henry F.
5245 Washington Blvd. (20)
Beeler, Raymond C.
712 Hume Mansur Bldg. (4)
Berger, Henry I...3650 College (5)
Berman, Jacob K.
807 Hume Mansur Bldg. (4)
Beverland, Malon E.
3036 E. Washington (1)
Bibler, Lester D.
811 Underwriters Bldg. (4)
Billings, Elmer R...Gen. Hosp. (7)
Bird, Charles R.
301 Hume Mansur Bldg. (4)
Blatt, A. Ebner
3209 N. Meridian (8)
Bloemker, Edward F.
2729 Shelby (3)
Bock, Don G...Methodist Hosp. (7)
Boggs, Eugene F.
4104 Madison (3)
Bohner, Caryle B.
822 Hume Mansur Bldg. (4)
Boling, Grover C., Jr.
Methodist Hosp. (7)
Booher, Norman R.
447 E. Maple Rd. (5)
Booher, Olga Bonke
447 E. Maple Rd. (5)
Bower, Daniel L.
3377 Forest Manor (18)
Bowman, George W.
1140 E. Market (2)
Boyd, Foster J., Jr..Gen. Hosp. (7)
Boyer, Edward B.
725 Hume Mansur Bldg. (4)
Boyer, Floyd A...442 N. Drexel (1)
Brady, Thomas A.
818 Hume Mansur Bldg. (4)
Brayton, John R.
704 Underwriters Bldg. (4)
Brayton, Lee...3342 N. Illinois (8)
Brodie, Donald W.
817 C. of C. Bldg. (4)
Brother, George M.
1330 W. Michigan (7)
Brown, Archie E.
1220 S. Belmont (21)
Brown, David E.
520 Hume Mansur Bldg. (4)
Brown, DeWitt W.
209 Hume Mansur Bldg. (4)
Brown, Edward A. (H)
201 Fountain Sq. Th. Bldg. (3)
Brown, Frances T.
2126 N. Talbot (2)
Brown, James M.
St. Vincent's Hosp. (7)
Brown, Wendell E.
802 C. of C. Bldg. (4)
Browning, James S.
3209 N. Meridian (8)
Browning, William M.
3740 Central (5)

MARION COUNTY

(Indianapolis—Continued)

Breutsch, Walter L.
Central State Hospital (22)
Brunoehler, Carl J. . . Gen. Hosp. (7)
Buck, Charles E.
I. U. Medical Center (7)
Buckner, George D.
Methodist Hosp. (7)
Bunde, Carl A.
Pitman-Moore Co. (6)
Bundy, Merle . 1330 W. Michigan (7)
Burdette, Harold F.
3202 N. Meridian (8)
Burghard, Rolla D.
3760 N. Sherman Dr. (18)
Burnett, Arthur
I. U. Medical Center (7)
Burney, Leroy E.
1330 W. Michigan (7)
Buttz, Rose J. P. . . . 112 E. 13th (2)

C

Cahal, Ernest . . . . . 2614 Shelby (3)
Cahn, Hugo M. . . . . 506 E. 30th (5)
Call, Herbert F.
321 Hume Mansur Bldg. (4)
Campbell, John A.
I. U. School of Medicine (7)
Canaday, James W.
1229 Prospect (3)
Caplin, Irvin . . 2033 N. Harding (2)
Caplin, Samuel S. . . . 111 E. 30th (5)
Carson, Wayne
1011 Hume Mansur Bldg. (4)
Carter, James C.
502 Hume Mansur Bldg. (4)
Carter, Oren E. . . . . 668 E. 38th (5)
Caseley, Donald
I.U. Med. Center (7)
Cayley, Frank J.
Central State Hospital (22)
Chattin, Wm. R.
St. Vincent's Hosp. (7)
Chen, Ko Kuei . . Eli Lilly & Co. (6)
Chroniak, Walter . . . VA Hosp. (22)
Clark, Cecil P.
922 Hume Mansur Bldg. (4)
Clark, Cyrus J. . 6325 Guilford (20)
Clark, Lawson J.
3736 N. Delaware (5)
Close, W. Donald
809 Hume Mansur Bldg. (4)
Coble, Ralph R.
3311 N. Meridian (8)
Cohen, Irving
St. Vincent's Hosp. (7)
Collins, Hubert L.
985 N. Arlington (19)
Collins, James N.
712 Hume Mansur Bldg. (4)
Conger, Elizabeth S. (H)
326 K. of P. Bldg. (4)
Conley, Joseph L.
2443 E. Washington (1)
Conway, Chester C.
4402 E. New York (1)
Conway, Glenn . . . 1620 S. East (25)
Cook, Charles J. (H)
2405 Carrollton (5)
Copeland, Samuel J.
427 Bankers Trust Bldg. (4)
Cornacchione, Matthew
814 S. East (25)
Cortese, James V. . 435 S. East (25)
Cortese, Thomas A.
435 S. East (25)
Courtney, John W.
518 Hume Mansur Bldg. (4)
Cox, Clifford E.
720 Underwriters Bldg. (4)
Cox, Harold B.
5316 E. Washington (19)
Craft, Kenneth L.
1002 Hume Mansur Bldg. (4)
Craig, Alexander
I. U. Medical Center (7)
Craven, Howard T.
Methodist Hosp. (7)
Culbertson, Clyde G.
Lilly Research Lab. (6)
Cullen, Paul K.
422 Hume Mansur Bldg. (4)
Culloden, William G.
710 E. 46th (5)
Cunningham, John M.
508 Hume Mansur Bldg. (4)
Cuthbert, Marvin
203 Hume Mansur Bldg. (4)

D

Dalton, John E.
707-708 Hume Mansur Bldg. (4)
Dalton, William W.
209 Hume Mansur Bldg. (4)
Daniel, John C.
1008 Hume Mansur Bldg. (4)
Datzman, Richard C.
I. U. Medical Center (7)
Davidson, N. Cort
3008 Clifton (23)
Davis, John A. . . . 2719 E. Mich. (1)
Davis, Sam J.
908 Hume Mansur Bldg. (4)
Day, Clark W.
611 Bankers Trust Bldg. (4)
Deal, Eleanor H. B.
1544 Main St., Speedway (24)
Dearmin, Robert M.
3440 N. Meridian (8)
DeArmond, Murray
723 Hume Mansur Bldg. (4)
Deever, John W. . . . 4131 Shelby (3)
DeMotte, C. Bowen
808 C. of C. Bldg. (4)
Denny, Forrest L.
2724 W. 10th (22)
Denny, James W.
5504 E. Washington (19)
Des Jean, Paul A.
616 K. of P. Bldg. (4)
DeWees, Dwight L.
302 N. Bradley (1)
Dilts, Robert Louis
2521 E. 38th (18)
Dintaman, Paul G.
432 Bankers Trust Bldg. (4)
Dittmer, Thomas L.
3315 N. Gladstone (18)
Dolezal, Bernard J.
St. Vincent's Hospital (7)
Donato, Albert M. . 1521 Shelby (3)
Donner, Paul G.
Norways, 1800 E. 10th (1)
Dorman, Willis L.
5508 E. Washington (19)
Dowd, Joseph A. . 6202 College (20)
Dryden, Gale E. . . 5 S. Belmont (22)
Dugan, Thomas J.
2540 W. Washington (22)
Dugan, William M.
410 Hume Mansur Bldg. (4)
Dunbar, Colin V.
423-4 Hume Mansur Bldg. (4)
Dunning, Lehman M.
1561 College (2)
Dyar, Edwin W.
3202 N. Meridian (8)
Dyke, Richard W.
General Hospital (7)

E

Eastman, Joseph R., Jr.
822 Hume Mansur Bldg. (4)
Eaton, Edwin R.
3120 N. Meridian (8)
Ebert, J. Wayne . . . 509 Lincoln (3)
Eberwein, John H.
414 E. Fall Ck. Pkwy., N. D. (5)
Egbert, Herbert L. . . VA Hosp. (22)
Egbert, Roy
2601 Roosevelt Ave. (18)
Eicher, Palmer O.
3209 N. Meridian (8)
Eikenberry, Hugh W.
616 Bankers Trust Bldg. (4)
Eldridge, Gail E. . . . 1440 E. 4th (5)
Ellis, Bert E.
303 Hume Mansur Bldg. (4)
Emhardt, John T. . 1621 S. East (25)
Emhardt, John W. A.
709 Underwriters Bldg. (4)
Ensminger, L. A.
908 Hume Mansur Bldg. (4)
Enzor, Ora K. . . . . 4216 College (5)
Ernst, Clifford E.
428 Bankers Trust Bldg. (4)
Evans, Frederick H.
606 N. Senate (2)
Evans, Paul V. . . General Hosp. (7)
Everly, Ralph V. . . 4216 College (5)

F

Failey, Robert B., Jr.
420 Hume Mansur Bldg. (4)
Farrell, Joseph T.
2807 E. Michigan (1)
Fausset, C. Basil
408 Hume Mansur Bldg. (4)
Fisk, Frank B. . . . 1200 Madison (6)
Fitzgerald, William J.
203 Ftn. Sq. Bldg. (3)
Flanigan, Meredith B.
2920 W. 33rd (22)
Flick, John J. . . . . 1443 N. Penn. (2)
Flora, Joseph O.
4317 W. Washington (21)
Folkening, Norval C.
204 Ftn. Sq. Bldg. (3)
Foreman, Harry L. . . 60 W. 30th (8)
Forry, Frank
I. U. Medical Center (7)
Fosler, David W.
710 Underwriters Bldg. (4)
Fouts, Paul J.
522 Hume Mansur Bldg. (4)
Franklin, William L.
508 Hume Mansur Bldg. (4)
Frazin, Bernard
Billings VA Hospital
Ft. Benj. Harrison (16)
Frost, John W.
740 S. Alabama (6)
Fry, Robert D.
612 Hume Mansur Bldg. (4)
Fullerton, Robert L. . 3665 N. Ill. (8)
Funkhouser, Arthur G.
702 Underwriters Bldg. (4)

MARION COUNTY
(Indianapolis—Continued)

Funkhouser, Elmer
702 Underwriters Bldg. (4)
Furgason, Paul C.
1008 Hume Mansur Bldg. (4)
Furniss, Sumner A. (H)
406½ Indiana (2)

G

Gabe, William E.
612 Hume Mansur Bldg. (4)
Gaddy, Euclid T.
2602 W. Washington (22)
Gallup, Palmer R.
601 Inland Bldg. (4)
Gambill, William D.
1019 Hume Mansur Bldg. (4)
Gammieri, Robert L.
3326 Clifton (23)
Garber, J. Neill
1024 Hume Mansur Bldg. (4)
Garceau, George J.
508 Hume Mansur Bldg. (4)
Gardiner, Sprague H.
314 Hume Mansur Bldg. (4)
Gardner, Buckman
St. Vincent's Hospital (7)
Garfield, Martin D.
3705 College (5)
Garner, William (H)
2911 E. 10th (1)
Garner, W. Stanley
2911 E. 10th (1)
Garrett, John D. (H)
510 Doctors Bldg. (4)
Garrett, Robert A.
I. U. Medical Center (7)
Gaskill, Herbert S.
I. U. Medical Center (7)
Gastineau, Frank M.
407 Hume Mansur Bldg. (4)
Gatch, W. D.
605 Hume Mansur Bldg. (4)
Geider, Roy A...1443 Prospect (3)
George, Charles L..507 E. 34th (5)
Gibson, Maxine
3015 N. Meridian, No. 308 (8)
Gick, Herman H.
2705 E. Michigan (1)
Gifford, Fred E.
710 Hume Mansur Bldg. (4)
Gillespie, Charles F.
3209 N. Meridian (8)
Gish, Howard M.
Methodist Hosp. (7)
Gillespie, Jacob E.
523 Hume Mansur Bldg. (4)
Givner, David
Billings VA Hospital,
Ft. Benj. Harrison (16)
Glass, Robert L.
608 Hume Mansur Bldg. (4)
Glendening, John L.
132 Insurance Bldg. (4)
Gosman, James H.
407 Hume Mansur Bldg. (4)
Gotlib, Milton H.
St. Vincent's Hosp. (7)
Graf, John P.
I. U. Medical Center (7)
Graves, John W...4734 E. 10th (1)
Graves, Noel S.
Methodist Hosp. (7)
Green, Oscar
I. U. Medical Center (7)
Green, Paul A...General Hosp. (7)
Greist, John H.
202 Hume Mansur Bldg. (4)
Griffith, Ross E.....401 E. 34th (5)
Grisell, Ted L.
504 Hume Mansur Bldg. (4)
Gunderson, Shaun D.
General Hospital (7)
Gustafson, Gerald W.
314 Hume Mansur Bldg (4)
Gutelius, Charles B.
900 Underwriters Bldg. (4)
Guthrie, James R.
I. U. Medical Center (7)

H

Habich, Carl
702 Hume Mansur Bldg. (4)
Hadley, David
809 Hume Mansur Bldg. (4)
Hadley, Murray N. (H)
809 Hume Mansur Bldg. (4)
Haggard, Edmund B.
806 Board of Trade Bldg. (4)
Hahn, E. Vernon
914 Hume Mansur Bldg. (4)
Hall, Frank M.
701 Board of Trade Bldg. (4)
Hall, Jack R....3342 N. Illinois (8)
Hallam, F. Tulley
1129 State Life Bldg. (4)
Hamer, Homer G.
1711 N. Capitol (7)
Hampshire, Donald R.
1443 N. Pennsylvania (2)
Hancock, John G.
2226 W. Michigan (22)
Hanley, Edward J., Jr.
General Hospital (7)
Hanna, Thomas A.
1462 Main St., Speedway (24)
Hansell, R. M.....7 N. Euclid (1)
Harcourt, Allan K.
812 C. of C. Bldg (4)
Harding, Myron S.
308 Hume Mansur Bldg. (4)
Harding, M. Richard
308 Hume Mansur Bldg. (4)
Hare, Earl H.....VA Hospital (22)
Hare, Laura
404 Hume Mansur Bldg. (4)
Harger, Robert W.
I. U. Medical Center (7)
Harold, Albert H.
7510 Allisonville Rd. (44)
Harold, Norris E. (H)
653 West 30th St.
Harris, Carl B.
319 Hume Mansur Bldg. (4)
Harris, Paul N.
Eli Lilly & Co. (6)
Hasewinkel, Carroll W.
Methodist Hospital (7)
Hasler, Norman B.
Sunnyside Sanatorium (44)
Haslinger, Clarence J.
215 E. New York (1)
Hatfield, B. F.
802 C. of C. Bldg. (4)
Hatfield, Jack J.
802 C. of C. Bldg. (4)
Hatfield, N. W..2032 N. Rural (18)
Hawk, James H.
514 Hume Mansur Bldg. (4)
Haymond, Joseph L.
3769 College (5)
Hays, Everett L. Billings VA Hosp.,
Ft. Benj. Harrison (16)
Hedrick, Philip W.654 E. 54th (20)
Heinz, Dorothy C. V...Ind. Council
for Mental Hlth., Fairgrounds (5)
Henderson, F. G. Eli Lilly & Co. (6)
Hendricks, J. D....2230 N. Del. (5)
Hendricks, John W.
911 Hume Mansur Bldg. (4)
Hennessee, Philip C.
320 Hume Mansur Bldg. (4)
Henry, Russell S.
725 Hume Mansur Bldg. (4)
Hepburn, C. K.
524 Hume Mansur Bldg (4)
Herrmann, Gordon T.
I.U. Med. Center (7)
Hetherington, A. M.
4121 E. New York (1)
Hetherington, John A.
910 Hume Mansur Bldg. (4)
Heubi, J. E...668 E. Maple Rd. (5)
Hickman, W. F....1210 Oliver (21)
Himebaugh, James R. S.
513 S. Sherman Dr. (3)
Himler, James M.
809 Underwriters Bldg.(4)
Hine, U. B.....4808 E. Mich. (1)
Hines, Don C...Eli Lilly & Co. (6)
Hippensteel, R. R...401 E. 34th (5)
Hodges, Fletcher
VA Regional Office (4)
Hofmann, J. William
323 Hume Mansur Bldg. (4)
Hollingsworth, A. A.
4032 E. Wash. (1)
Holman, J. E., Jr..3315 E. 10th (1)
Holman, Jerome E., Sr.
523 Bankers Tr. Bldg. (4)
Holmes, Claude, Jr.
510 Winona Village (7)
Hood, A. A.....1413 Roache (23)
Horwitz, Thomas
423-4 Hume Mansur Bldg. (4)
Houseworth, John H.
Sunnyside Sanatorium (44)
Howell, Joseph D.
760 Bankers Tr. Bldg. (4)
Howell, Robert D.
900 Underwriters Bldg. (4)
Hoyt, L. H....Methodist Hosp. (7)
Huber, Carl P.
I.U. Med. Center (7)
Huckeriede ,Mark H.
Methodist Hosp. (7)
Hudson, F. J..3440 N. Meridian (8)
Hughes, William F. (H)
401 Hume Mansur Bldg. (4)
Hull, Ronald H.
914 Hume Mansur Bldg. (4)
Hummons, H. L...729½ N. West (2)
Hurt, Laverne B.
635 E. Kessler Blvd. (20)
Huse, William M.
St. Vincent's Hosp. (7)

I

Irwin, Glenn W., Jr.
I.U. Med. Center (7)
Iske, Paul G.
1015 Hume Mansur Bldg. (4)

J

Jackson, Frederick E.
510 Doctors Bldg. (4)
Jackson, James W.
1330 W. Mich. (7)

MARION COUNTY

(Indianapolis—Continued)

Jackson, J. L. . . . . 3001 E. 10th (1)
Jackson, J. F. . . . . 2134 Admiral Dr.
Jacobs, Harry A.
332 Bankers Tr. Bldg. (4)
Jaeger, A. S.
430 Bankers Tr. Bldg. (4)
Jaquith, Orville S. (H)
261 Blue Ridge Rd. (8)
Jay, A. N. . . . 3120 N. Meridian (8)
Jeffries, K. I. . . . . 807 Virginia (3)
Jenkins, R .E .3311 N. Meridian (8)
Jennings, Frank L.
Sunnyside Sanatorium (44)
Jewett, J. H. . 3120 N. Meridian (8)
Jinks, C. H. . . . . 4216 College (5)
Jobes, James E.
305 Traction Term. Bldg. (4)
Jobes, Norman E. (H)
305 Traction Term. Bldg. (4)
Johnson, Thomas W.
529 Bankers Tr. Bldg. (4)
Johnson, W. F 2121 N. Harding (2)
Johnston, Donald D.
Veterans Administration
Jones, David E.
828 C. of C. Bldg. (4)
Jones, F. P. . . 4305 E. Michigan (1)
Joseph, R. M. . . . . 1615 S. East (25)

K

Kahler, M. V. . 2338 W. Mich. (22)
Kahn, A. J. . . . 3120 N. Meridian (8)
Kahn, H. L. . . 3120 N. Meridian (8)
Kalb, E. L. . . . . 5934 E. 21st (18)
Kammen, Leo . . . . 3414 Clifton (23)
Kammen, Robt. . . 3202 W. 16th (22)
Katterjohn, James C.
313 Hume Mansur Bldg. (4)
Kauffman, Nelson N.
323 Hume Mansur Bldg. (4)
Kauffman, Sidney A.
226 Hume Mansur Bldg. (4)
Keenan, R. L. . 812 C. of C. Bldg. (4)
Keever, C. H. . . . . 5214 College (20)
Keiser, Venice D.
646 Bankers Tr. Bldg. (4)
Kelley, Clement E.
Methodist Hosp. (7)
Kelly, Don E.
702 Underwriters Bldg. (4)
Kelly, John F.
517 Hume Mansur Bldg. (4)
Kelly, Walter F. (H)
5503 E. Washington (19)
Kelly, W. M. . . . 5438 E. Wash. (19)
Kempf, G. F. . . . . 307 City Hall (4)
Kendrick, W. M. . 1829 E. 46th (5)
Kennedy, Hall .2152 N. Meridian (2)
Kennedy, H. F. . . 1105 Prospect (3)
Kerr, H. R. . . . . 2817 E. Wash. (1)
Ketcham, Jane M.
514 Hume Mansur Bldg. (4)
Kilgore, B. W. . . . 3133 E. 38th (18)
Kime, Edwin N.
711 Underwriters Bldg. (4)
King, William E.
811 Hume Mansur Bldg. (4)
King, W. F. (H) .1330 W. Mich. (7)
Kingsbury, John K.
5462 E. Washington (19)
Kinzel, Robert J. W.
3120 N. Meridian (8)
Kirkhoff, Paul J.
St. Vincent's Hosp. (7)
Kirklin, Oren L.
817 Hume Mansur Bldg. (4)
Kirtley, William R.
Lilly Research Lab. (6)
Kiser, Edgar F.
226 Hume Mansur Bldg. (4)
Kitterman, Harry E.
510 Hume-Mansur Bldg. (4)
Klain, B. V. . . . . 4157 College (5)
Kneidel, J. H. . . Billings VA Hosp.,
Ft. Benj. Harrison (16)
Knowles, C. Y. . . . . 4625 E. 10th (1)
Kohlstaedt, George W.
422 Hume Mansur Bldg. (4)
Kohlstaedt, Karl C.
422 Hume Mansur Bldg. (4)
3660 W. 16th (2))
Kohlstaedt, Kenneth G.
General Hosp. (7)
Koons, Karl M.
922 Hume Mansur Bldg. (4)
Kopecky, R. R. . . . . 814 S. East (25)
Kopp, H. S. . . 975 N. Emerson (19)
Kornafel, L. H.
608 K. of P. Bldg. (4)
Kraft, Bennett
760 Bankers Tr. Bldg. (4)
Kuntz, Herman W.
501 Hume Mansur Bldg. (4)
Kurtz, Fred B.
315 Bankers Tr. Bldg. (4)
Kurtz, P. L. . . . . 668 E. 38th (5)
Kwitny, I. J. . . 3209 N. Meridian (8)

L

LaDine, C. B. . . . . 2440 Station (18)
Lamb, Emmett B.
205 Hume Mansur Bldg. (4)
Lamb, Russell W.
205 Hume Mansur Bldg. (4)
Lamber, Chet K.
912 Hume Mansur Bldg. (4)
Langdon, Harry K. (H)
3264 N. Penn. (5)
Larkin, Bernard J.
305 Hume Mansur Bldg. (4)
Lawler, G. F. . . . . 3934 E. 10th (1)
Lawrence, Edwin A.
I.U. Med. Center (7)
Layman, D. W. . . 3256 N. Penn. (5)
Leasure, J. Kent
611 Hume Mansur Bldg. (4)
Leatherman, Harter L.
1531 Broadway (2)
Leff, Abe H. . . . . 712 E. 52nd (5)
Leffel, James M., Jr.
3209 N. Meridian (8)
Leiter, Arthur . . . . . VA Reg. Office
Leonard, Henry S. (H)
303 Hume-Mansur Bldg. (4)
Leser, Ralph U.
207-8 Hume Mansur Bldg. (4)
Levi, Leon . . . . . 40 W. 38th (8)
Levin, R. T. . . 3209 N. Meridian (8)
Lichtenberg, Melvin
535 E. 38th (5)
Lidikay, Edward C.
915 Hume Mansur Bldg. (4)
Lindenborg, Paul G.
1402 N. Olney (1)
Lingeman, Raleigh E.
411 Hume Mansur Bldg. (4)
Lingeman, Roger E.
4143 Blvd. Place (8)
Link, Goethe
608 Ind. Pythian Bldg. (4)
Littell, J. Jerome
603 Hume Mansur Bldg. (4)
Little, J. W. (H) . . 2735 E. 10th (1)
Lochry, Ralph L.
St. Vincent's Hosp. (7)
Lockhart, Philip B.
University Hosps. (7)
Loehr, William M.
712 Hume Mansur Bldg. (4)
Loomis, Norman S.
804 Hume Mansur Bldg. (4)
Lord, G. C. . . . 104 E. Maple Rd. (5)
Lorman, James G.
I.U. Med. Center (7)
Love, G. N. . . . Methodist Hosp. (7)
Ludwig, O. D. . . . . 5433 Madison (3)
Lukemeyer, George T.
I.U. Med. Center (7)
Lybrook, William B.
3749 N. Keystone (18)

M

MacDonald, John A.
408 Hume Mansur Bldg. (4)
McBride, James S.
810 Hume Mansur Bldg. (4)
McCallum, J. T. C. 237 W. 46th (8)
McCarthy, Daniel J. (H)
507 Hume Mansur Bldg. (4)
McCartney, D. H. . . . VA Hosp. (22)
McCaskey, Carl H.
608 Guaranty Bldg. (4)
McCormick, C. O., Jr.
621 Hume Mansur Bldg. (4)
McCormick, C. O., Sr.
621 Hume Mansur Bldg. (4)
McCown, Percy E.
521 Hume Mansur Bldg. (4)
McDevitt, Daniel R.
3202 N. Meridian (8)
McGrath, M. F. . . 1929 E. 38th (18)
McGuff, P. E. . 605 E. Maple Rd. (5)
McIntire, Clarence R.
3202 Meridian (8)
McIntyre, Charles J.
414 Hume Mansur Bldg. (4)
McIntyre, J. M.
806 Hume Mansur Bldg. (4)
McKay, Robert
Central State Hosp. (22)
McKinley, A. David
I.U. Hospitals (7)
McMillan, Frederick G.
1110 Odd Fellows Bldg. (4)
McNamara, J. P. . 5610 College (20)
McQuiston, Ralph J.
608 Guaranty Bldg. (4)
McTurnan, Robert W.
5646 N. Illinois (8)
Mackey, J. E. . . . General Hosp. (7)
Mackey, H. S. . . . . 4309 Central (5)
Madtson, A. R. . . 5238 College (20)
Magennis, H. L. . 468½ W. Wash. (4)
Manalan, M. M. . . . . VA Hosp. (22)
Manion, Marlow W.
601 Hume Mansur Bldg. (4)
Mann, Mortimer
323 Hume Mansur Bldg. (4)
Manning, J. C., Jr.
1015 Hume Mansur Bldg. (4)
Manning, K. Randolph
723 Hume Mansur Bldg. (4)
Marshall, A. L., Jr.
3465 Carrollton (5)
Marshall, C. R. . . . . 43 W. 30th (8)
Martin, C. F., Jr .Billings VA Hosp.,
Ft. Benj. Harrison (16)

MARION COUNTY
(Indianapolis—Continued)

Martin, H. E.....1200 Madison (6)
Martin, L. H...2626 W. Wash. (22)
Martz, Bill L....General Hosp. (7)
Martz, Carl D.
508 Hume Mansur Bldg. (4)
Marvel, R. J.....General Hosp. (7)
Masters, John M.
805 Hume Mansur Bldg. (4)
Masters, Robert J.
805 Hume Mansur Bldg. (4)
Mather, R. L..I.U. Med. Center (7)
Matthew, W. Burleigh
520 Hume Mansur Bldg. (4)
Matthews, B. J....4612 E. 10th (1)
Matthews, W. M...4612 E. 10th (1)
Maxson, Roy V.....VA Hosp. (22)
Megenhardt, D. S.
1015 Hume Mansur Bldg. (4)
Meiks, Lyman T....Riley Hosp. (7)
Melloh, A. F.....2821 E. 10th (1)
Mendenhall, Clarence D.
4502 E. Wash. (1)
Mendenhall, W. E.515 N. Rural (1)
Mentendiek, Maurice H.
205 Hume Mansur Bldg. (4)
Mericle, Earl W.
209 Hume Mansur Bldg. (4)
Merrell, Paul
914 Hume Mansur Bldg. (4)
Mertz, H. O....1711 N. Capitol (7)
Michael, A. C...1040 W. Mich. (7)
Micheli, Arthur J.
920 Underwriters Bldg. (4)
Middleton, H. N....1828 N. Ill. (2)
Miller, A. W....207 E. Morris (25)
Miller, Iva M...2458 N. Kitley (18)
Miller, J. Don
514 Hume Mansur Bldg. (4)
Miller, John R.....953 E. Tabor
Miller, R. S.....6211 College (20)
Miller, R. D.....3769 Park (5)
Millikan, William J.
3736 N. Delaware (5)
Mitchell, E. H.....1023 King (22)
Moenning, Walter P.
618 K. of P. Bldg (4)
Molt, William F.
529 Bankers Tr. Bldg. (4)
Montgomery, William F.
311 Hume Mansur Bldg. (4)
Moore, Ben B.
414 Hume Mansur Bldg. (4)
Moore, H. T...3220 N. Sharon (22)
Moore, Robert M.
1007 Hume Mansur Bldg. (4)
Morchan ,Saml....3769 College (5)
Morec, G. J.....General Hosp. (7)
Morford, Guy
3812 N. Dearborn (18)
Moriarty, John R.
5602 Madison (3)
Morrison, Lewis E.
503 Hume Mansur Bldg. (4)
Morton, Walter P.
623 Hume Mansur Bldg. (4)
Moser, Rollin H.
408 Hume Mansur Bldg. (4)
Moss, H. B.....1849 Nowland (1)
Mothersill, M. H.Eli Lilly & Co. (6)
Moulton, L. G....1327 N. Penn. (2)
Mozingo, Arvine E.
1129 S. Meridian (25)
Mueller, L. B....General Hosp. (7)
Muller, L. P.....5608 College (20)
Muller, P. F..3311 N. Meridian (8)
Mumford, E. B.320 N. Meridian (4)
Myers, Chas. W..General Hosp. (7)
Myers, R. V....1904 N. Rural (19)

N

Nafe, Cleon A.
822 Hume Mansur Bldg. (4)
Nay, Richard M.
214 Hume Mansur Bldg. (4)
Need, L. T...1927 S. Meridian (25)
Neely, Alonzo S.
305 Fountain Sq. Bldg. (3)
Nehil, Lawrence W.
1011 Hume Mansur Bldg. (4)
Neier, O. C.(H).5508 E. Wash. (19)
Nester, H. G.....General Hosp. (7)
Nie, Louis W.
202 Hume Mansur Bldg. (4)
Noble, Thomas B., Jr.
1008 Hume Mansur Bldg. (4)
Noe, Wm. R...Methodist Hosp. (7)
Nolting, H. F.....261 W. 40th (8)
Nonte, Leo R...Billings VA Hosp.,
Ft. Benj. Harrison (16)
Norman, Olin B.
922 Hume Mansur Bldg. (4)
Norman, William H.
908 Hume Mansur Bldg. (4)
Norris, Howard Lee
704 Hume Mansur Bldg. (4)
Norris, Mary Alice
404 Hume Mansur Bldg. (4)
Nourse, M. H..1711 N. Capitol (7)
Nugent, E. J.Allison Div. GMC (6)

O

Ochsner, H. C..Methodist Hosp. (7)
Olvey, O. N.....3809 Central (5)
Orders, Clark E.
440 Bankers Tr. Bldg. (4)
Oswald, R. H...Coleman Hosp. (7)
Otten, Claude F.
812 C. of C. Bldg. (4)
Ottinger, Ross C.
912 Hume Mansur Bldg. (4)
Owen, John E.
605 Hume Mansur Bldg. (4)
Owens, T. C..2823 N. Meridian (8)

P

Padgett, Everett E.
424 Hume Mansur Bldg. (4)
Pandolfo, Harry.2206 Madison (25)
Parker, G. F., Jr..6156 E. 21st (18)
Parker, J. F.....1706 E. Wash. (1)
Parker, Portia.2226 W. Mich. (22)
Patton, M. T.....107 W. 30th (8)
Paulissen, G. T.....310 E. 24th (5)
Peacock, R. C.....General Hosp. 7)
Pearson, Lyman R.
311 Hume Mansur Bldg. (4)
Pebworth, Aubrey C.
1625 W. Morris (21)
Peck, F. B.....740 S. Alabama (6)
Peirce, J. D.....Eli Lilly & Co. (6)
Pennington, Walter E.
214 Hume Mansur Bldg (4)
Permer, Erwin.....134 E. 30th (5)
Peters, Elmer E.
St. Vincent's Hosp. (7)
Peters, R. J. D...3203 E. Mich. (1)
Petranoff, T. V..3367 W. Mich. (22)
Pettijohn, Fred L. (H)
2460 Central (5)
Pfaff, John A. (H)
703 Hume Mansur Bldg. (4)
Pfafflin, Charles A. (H)
1844 N. Penn. (2)
Pickett, Robert D.
408 Hume Mansur Bldg. (4)
Pilcher, Jack E.
201 Hume Mansur Bldg. (4)
Pollak, Lewis....1602 N. Penn. (2)
Powell, Horace M., Jr.
Methodist Hosp. (7)
Price, James O.
906 Hume Mansur Bldg. (4)
Pryor, R. C.....6111 College (20)

Q

Quigley, Jos. B....2120 E. 10th (1)

R

Rabb, Frank M.....4146 N. Ill. (8)
Rabb, H. S.....3139 E. 10th (1)
Raber, Robt. M.....VA Hosp. (22)
Radding, R. S....General Hosp. (7)
Rader, George S.
624 Hume Mansur Bldg. (4)
Radigan, L. R.I.U. Med. Center (7)
Ramsey, Frank B.
201 Hume Mansur Bldg. (4)
Reed, Jewett V.
820 C. of C. Bldg. (4)
Reed, Philip B....1800 E. 10th (1)
Rees, R. C.....6114 E. Wash. (19)
Reid, Chas. A.....2445 Shelby (3)
Reisler, Simon
318 Bankers Tr. Bldg. (4)
Rhodes, Theodore D.
307 Hume Mansur Bldg. (4)
Rice, R. M.....740 S. Alabama (6)
Rice, T. B..State Bd. of Health (7)
Richardson, Thad T.
5508 E. Wash. (19)
Richter, Arthur B.
720 Hume Mansur Bldg. (4)
Ricketts, J. W.
806 Hume Mansur Bldg. (4)
Ridgeway, O. W....411 E. 16th (2)
Rigg, John F.
421 Hume Mansur Bldg. (4)
Ritchey, James O.
608 Hume Mansur Bldg. (4)
Ritter, Wayne L.
404 Hume Mansur Bldg. 4)
Robb, John A.
238 Hume Mansur Bldg. (4)
Robertson, R. B.6118 E. Wash. (19)
Roller, C. W.....1437 Shelby (3)
Romberger, F. T., Jr.
3440 N. Meridian (8)
Rosenak, Bernard D.
226 Hume Mansur Bldg. (4)
Rosenbaum, David..VA Hosp. (22)
Rosenbaum, Irving, Jr.
712 E. 63rd (20)
Ross, A. T....I.U. Med. Center (7)
Rothenberger, Daniel J.
St. Vincent's Hosp. (7)
Rothring, H. E...General Hosp. (7)
Row, D. Hamilton
906 Hume Mansur Bldg. (4)
Rubin, Gerald S.
620 Hume Mansur Bldg. (4)
Ruddell, Karl R.
3202 N. Meridian (8)

MARION COUNTY
(Indianapolis—Continued)

Ruddell, Keith R.
3202 N. Meridian (8)
Rudesill, Cecil L.
405 Hume Mansur Bldg. (4)
Rudesill, Robt..Methodist Hosp. (7)
Rudolph, Stephen J., Jr.
1638 N. Meridian (2)
Rupel, Ernest
419 Hume Mansur Bldg. (4)
Rust, B. K.....3740 Central (5)
Ruth, M. L.....4304 E. Wash. (1)
Rutherford, C. W.4601 N. Penn. (5)
Ryan, G. V.....2428 W. 16th (22)

S

Sage, Russell A.
505 Hume Mansur Bldg. (4)
Salb, Max C..826 C. of C .Bldg. (4)
Salkin, Irwin
Robert Long Hosp. (7)
Sallee, Wm. T.
St. Vincent's Hosp. (7)
Salzman, Morris
1119 S. Meridian (25)
Sanders, Harry M.
3760 N. Sherman Dr. (18)
Sandorf, Marvin.1102½ Prospect (3)
Schaefer, C. Richard (H)
224 N. Meridian, No. 20 (4)
Schechter, John S.
3209 N. Meridian (8)
Scheier, E. W....1706 Prospect (3)
Schlaegel, T. F., Jr.
I.U. Med. Center (7)
Schmidt, L. F..Methodist Hosp. (7)
Schmidt, R. H..Methodis tHosp. (7)
Schneider, C. J..1008 N. Beville (1)
Schuchman, Gabriel
3451 College (5)
Schuster, Dwight W.
723 Hume Mansur Bldg. (4)
Schweitzer, Ada E. (H)
5736 Michigan Rd. (20)
Scott, Geo....3055 N. Meridian (8)
Scott, I. W...3209 N. Meridian (8)
Scott, J. S.....I.U. Med. Center (7)
Scott, R. P..St. Vincent's Hosp. (7)
Scott, S. L....Veterans Hosp. (22)
Seaman, Charles F.
1010 Hume Mansur Bldg. (4)
Seaton, Albert...American United
Life Ins. Co., Box 368 (6)
Sedam, H. L.....4173½ College (5)
Segar, Louis H.
226 Hume Mansur Bldg. (4)
Seitz, Philip F. D.
I.U. Med. Center (7)
Sexson, H. T.....1301 College (2)
Shafer, Marion R.
614 Hume Mansur Bldg. (4)
Sheehan, F. G..5503 E. Wash. (19)
Sherster, H..1135 S. Meridian (25)
Shrigley, Edward W.
I.U. Med. Center (7)
Shugart, Joseph A.
St. Vincent's Hosp. (7)
Shullenberger, W. A.
3740 Central (5)
Shumacker, Harris B., Jr.
I.U. Med. Center (7)
Sicks, Okla W.
1010 Hume Mansur Bldg. (4)
Sidebottom, Earl..Meth. Hosp. (7)
Siekerman, C. W. 2612 Madison (3)
Siersdorfer, Theodore N.
6003 W. Wash. (21)
Sigmond, Harvey W.
301 Hume Mansur Bldg. (4)
Simms, J. Leon
2638½ Northwestern (23)
Simpson, W. D...6104 E. 21st (18)
Sims, J. Lawrence
809 Hume Mansur Bldg. (4)
Slocum, Y. K...Billings VA Hosp.,
Ft. Benj. Harrison (16)
Sluss, D. H...808 C. of C. Bldg. (4)
Sluss, John W. (H)
808 C. of C. Bldg. (4)
Smiley, J. H.....4201 E. Mich. (1)
Smith, D. J.
910 Hume Mansur Bldg. (4)
Smith, David L.
723 Hume Mansur Bldg. (4)
Smith, E. Rogers
822 Hume Mansur Bldg. (4)
Smith, F. C..983 N. Arlington (19)
Smith, Jas. M...700 Test Bldg. (4)
Smith, Lester A.
238 Hume Mansur Bldg. (4)
Smith, Roy Lee
707 Underwriters Bldg. (4)
Smith, W. F.....3424 College (5)
Smith, William B.
2229 Northwestern (23)
Snider, Byron....2717 S. East (3)
Solomon, Reuben A.
414 Hume Mansur Bldg. (4)
Souter, M. C..3360 N. Meridian (8)
Sovine, J. W.
720 Hume Mansur Bldg. (4)
Spahr, John F., Jr.
902 Hume Mansur Bldg. (4)
Spalding, Joseph J.
706 Hume Mansur Bldg. (4)
Sparks, Alan L.
1024 Hume Mansur Bldg. (4)
Spink, Urbana.....112 E. 13th (2)
Spivey, R .J.....2616 N. Penn. (5)
Spolyar, L. W...1330 W. Mich. (7)
Sputh, Carl B., Jr.
301 Doctors Bldg. (4)
Sputh, Carl B., Sr.
301 Doctors Bldg. (4)
Stadler, H. E...5508 E. Wash. (19)
Stanley, J. S.....307 City Hall (4)
Stayton, Chester A., Jr.
313 Hume Mansur Bldg. (4)
Stayton, Chester A., Sr.
313 Hume Mansur Bldg. (4)
Steffy, R. M...Methodist Hosp. (7)
Stephens, D. E..6332 Guilford (20)
Stephens, K. H.
501 Hume Mansur Bldg. (4)
Stern, Nathan
601 Bankers Tr. Bldg. (4)
Stevens, S. L....General Hosp. (7)
Stoelting, V. K.
I.U. Med. Center (7)
Stone, A. T.....6202 College (20)
Stone, David F.
725 Hume Mansur Bldg. (4)
Storey, D. Edmund
813 Broad Ripple Ave. (20)
Storey, Jos. L.....3434 N. Ill. (8)
Storms, Roy B.
1014 Roosevelt Bldg. (4)
Stout, Francis E.
I.U. Med. Center (7)
Strange, D. C..I.U. Med. Center (7)
Stroup, T. J..216 K. of P. Bldg. (4)
Stucky, E. K....1355 Madison (25)
Stump, Thomas A.
127 Blue Ridge Rd. (8)
Stygall, James H.
1221 N. Delaware (2)
Sudranski, Herbert F.
624 Hume Mansur Bldg. (4)
Sutton, William E.
419 Hume Mansur Bldg. (4)
Swan, John R.
915 Hume Mansur Bldg. (4)
Swayne, J. F....1410 E. Wash. (1)
Symmes, Alfred T.
605 E. Maple Rd. (5)
Szynal, Jno. S.....VA Hosp. (22)

T

Talbott, Dan E.
1020 Hume Mansur Bldg. (4)
Tanner, Henry S.
301 Hume Mansur Bldg. (4)
Taylor, Clifford C.
St. Vincent's Hosp. (7)
Taylor, Frederic W.
408 Hume Mansur Bldg. (4)
Teague, Frank W.
501 Hume Mansur Bldg. (4)
Teixler, Victor A.
224 Hume Mansur Bldg. (4)
Terry, Willard B. G., Jr.
Methodist Hosp. (7)
Tether, J. E...I.U. Med. Center (7)
Tharpe, Ray..3202 N. Meridian (8)
Thatcher, Hugh K., Jr.
110 W. Maple Rd. (8)
Thom, J. W.....VA Reg. Office (4)
Thom, Julia S.....1820 E. 10th (1)
Thomas, Edw. P....463½ Blake (2)
Thomas, L. I..812 C. of C. Bldg. (4)
Thomas, Morris E.
445 N. Penn., No. 715 (4)
Thompson, Charles F.
818 Hume Mansur Bldg. (4)
Thompson, John V.
1221 N. Delaware (2)
Thompson, Paul D.
805 Hume Mansur Bldg. (4)
Thornburg, Kenneth E.
1015 Hume Mansur Bldg. (4)
Thornton, H. C..Marott Hotel (7)
Thrasher, John R.
823 C. of C. Bldg. (4)
Thurston, H. S..2503½ Prospect (3)
Tinney, William E.
900 Underwriters Bldg. (4)
Tinsley, Frank W.
603 K. of P. Bldg. (4)
Tinsley, Walter B.
603 K. of P. Bldg. (4)
Tischer, E. Paul
208 Hume Mansur Bldg. (4)
Torrella, J. A....5324 W. 16th (24)
Toumey, Fred L.
529 Bankers Tr. Bldg. (4)
Travis, J. C.
805 Underwriters Bldg. (4)
Trusler, Harold M.
1015 Hume Mansur Bldg. (4)
Tuchman, J. H.....845 Grove (3)
Tucker, R. L.....2952 Central (5)
Tucker, Warren S.
414 Hume Mansur Bldg. (4)

V

Vandivier, Robert M.
209 Hume Mansur Bldg. (4)

MARION COUNTY

(Indianapolis—Continued

Van Dorn, Myron J.
Methodist Hosp. (7)
Van Fleet, Josephine
I.U. Med. Center (7)
Van Meter, C. P...3419 E. 10th (1)
Van Nuys, John D.
I.U. Med. Center (7)
Van Osdol, Harry A.
828 C. of C. Bldg. (4)
Van Tassel, C. J., Jr.
I.U. Med. Center (7)
Van Vactor, Helen D.
226 Hume Mansur Bldg. (4)
Vollrath, V. J.....5202 N. Ill. (8)
Voyles, Charles F.
715 Underwriters Bldg. (4)

W

Wagner, Arthur L.
St. Vincenet's Horp. (7)
Waldo, J. Thayer
610 Hume Mansur Bldg. (4)
Wales ,Ernest de Wolfe (H)
1236 N. Penn. (2)
Walker, Frank C.
414 Hume Mansur Bldg. (4)
Walker, Robt. K....413 E. 34th (5)
Waller, John I.
407 Hume Mansur Bldg. (4)
Walther, J. E.3202 N. Meridian (8)
Ward, Joseph H.
2116 Boulevard Pl. (2)
Ward, W. C.....116 E. 49th (5)
Warfel, F. C.....VA Hosp. (22)
Warren, J. C.....5444 College (20)
Warriner, James B.
Methodist Hosp. (7)
Warvel, John H.
614 Hume Mansur Bldg. (4)
Waterman, John
I.U. Med. Center (7)
Waymire, E. S....1827 College (2)
Wehrman, Jule O. (H)
504 Hume Mansur Bldg. (4)
Weigand, C. G..740 S. Alabama (6)
Weil, H. J.....443 N. Hamilton (1)
Weinland, George C.
I.U. Med. Center (7)
Weiss, Jason....4909 W. 15th (24)
Weller, Charles A.
615 Hume Mansur Bldg. (4)
West, Jos. L...6318 W. Wash. (21)
Westfall, B. K....2901 E. 38th (18)
Westfall, John B.
2961 N. Sherman Dr. (18)
Weyerbacher, A. F.
709 Hume Mansur Bldg. (4)
Wheeler, John T. (H)
3130 N. Delaware (5)
White, Donald J.
502 Bankers Tr. Bldg. (4)
Whitehead, John M.
1544 Roosevelt (1)
Whitlock, F. C...4032 E. Wash. (1)
Whitt, J. D....Methodist Hosp. (7)
Wiethoff, Clifford A.
201 Hume Mansur Bldg. (4)
Wilkens, I. W.....1743 Shelby (3)
Williams, Chas. D..2405 Station (1)
Williams, Luther (H)
3540 N. Penn. (5)
Williams, Robert D.
St. Vincent's Hosp. (7)
Wilmore, Ralph C.
I.U. Med. Center (7)
Wilson, O. R..3519 Wash. Blvd. (5)
Winters, Matthew..508 E. 38th (5)
Wise, Wm.....120 E. 22nd (2)
Wishard, Wm. Niles, Jr.
1711 N. Capitol (7)
Wolfram, Don J.
208 Hume Mansur Bldg. (4)
Wood, D. E.....6325 Guilford (20)
Woodard, A. S., Jr.
668 E. Maple Rd. (5)
Worley, J. P....5831 E. Wash. (19)
Wright, J. William, Jr.
301 Hume Mansur Bldg. (4)
Wright, J. William, Sr.
301 Hume Mansur Bldg. (4)
Wyttenbach, F. C....1154 Lee (21)
3751 Farnsworth (21)
Wyttenbach, John E.
503 Hume Mansur Bldg. (4)

Y

Yochem ,August S., Jr.
General Hosp. (7)
Young, J. W.. 6302 Guilford (20)
Young, J. M..3209 N. Meridian (8)
Young, W. C....Eli Lilly & Co. (6)

Z

Zell, E. H....812 C. of C. Bldg. (4)
Zeps, E. F.....General Hosp. (7)
Zerfas, C. P. A.....2605 Shelby (3)
Zerfas, Phyllis K...2605 Shelby (3)
Ziperman, H. Haskell
I.U. Med. Center (7)

Bartle, James L.....Lawrence
Lewis, Robert J.....Lawrence
Asher, E. O.....New Augusta
Asher, James W.....New Augusta
Paynter, Morris B.....Southport
Jones, George L.....Wanamaker

Alward, John H.....City Hosp. of Akron, Akron, Ohio
Booth, Boynton H.....3720 Wash. Ave., St. Louis, Mo.
Chimento, Dominic F.
112 Tower St., Westerly, R. I.
Connerly, Marion L.
U. S. Naval Hosp., San Diego, Calif.
Dester, Herbert E.
Jagdeeshpur Via Raipur, C. P. India
Eckert, Russell A.
Illinois Masonic Hosp., Chicago 14, Ill.
Gallo, William C.....VA Hosp., Butler, Pa.
Griswold, Wait Robbins
U. S. Naval Hosp., Mare Island, Calif.
Harvey, Verne K.
39 River Road Terrace, Alexandria, Va.
Hill, Edward C.....78th Med. Grp., Hamilton A.F.B., Calif.
Hilldrup, Don G....Fort Sill, Okla.
Kenoyer, Wilbur L.....A.P.O. 677, c|o P.M., New York, N. Y.
Kloess, Edward J....56 Ftr. Wing, Selfridge A.F.B., Mt. Clemens, Mich.
Lambert, C. W...Orthopedic Hosp., 2400 St. Flower St., Los Angeles 7, Calif.
Lehman, Robert J....Pilgrim State Hosp., Brentwood, L.I., N.Y.
Masters, John B.....French Clinic, San Luis Obispo, Calif.
Meihaus, John E.....Sawtelle VA Hospital, Los Angeles, Calif.
Mitchell, Raymond E.
O'Reilly Veterans Hosp., Springfield, Mo.
Murray, James S...Stafford Hotel, Baltimore, Md.
Myers, Harold A.
1414 Air Base Sqd., 616 c|o P.M., New York, N. Y.
Norwick, Sydney S.
15816 Via Riveria, San Lorenzo, Calif.
Pebworth, James T....P.O. Box 69, Silver City, N. Mex.
Pierce, William J..145 Wash. Ave., Westville, Ill.
Ridgway, Alton H.
Belgian Congo, Africa
Rogers, Thomas P.
U. S. Naval Hosp., Bethesda, Md.
Roll, Edmund C..150 & 15th N. E., Seattle 55, Wash.
Schecter, William J.
4036 Wilshire Blvd., Los Angeles 5, Calif.
Sheridan, Joseph L.
St. Elizabeth Hosp., Washington, D. C.
Test, Charles E...1155 E. 56th St., Chicago 37, Ill.
Teter, George V., Jr.
U. S. Naval Dispensary, 50 Fell St., San Francisco, Calif.
Warman, Alvah
355-17th Ave., N.E., St. Petersburg, Fla.

MARSHALL COUNTY

Kelly, Frank H.....Argos
Sheller, Thomas G.....Argos
Connell, Vactor O.....Bourbon
Marshall, George L.....Bourbon
Bowen, Otis .....Bremen
Cripe, Earl P.....Bremen
Stine, Marshall E.....Bremen
Schreiner, John E.....Bremen
Baker, Milan D.....Culver
Bills, L. F.....R.R. 1, Culver
Witham, Robert L.....Culver
Connell, Paul S.....Plymouth
Irey, Paul R.....Plymouth
Kaler, James .....Plymouth
Klingler, Maurice O.....Plymouth
Kubley, James .....Plymouth
Pomeroy, Rex K.....Plymouth
Robertson, James S.....Plymouth
Stephens, R. Clarence (H)
Plymouth
Tripp, Harry D.....Plymouth
Vore, L. W.....Plymouth

MARSHALL COUNTY

(Continued)

Thompson, Alfred A.....Tyner
Holtzendorff, Charles F. (H)
2344 Oakdale St.,
St. Petersburg, Fla.

MARTIN COUNTY

(See Daviess-Martin)

MIAMI COUNTY

Shrock, Ethan E.....Amboy
Line, Homer E. .....Chili
Frybarger, Samuel S.....Converse
Malott, Frederick R.....Converse
Sennett, Wm. K. .....Macy
Waite, Earl L. .....Gilead
Rendel, Harold E. .....Mexico
Barnett, Ralph E. .....Peru
Berkebile, John B. .....Peru
Burrous, E. L. .....Peru
Carlson, E. A. (H).....Peru
Ferrera, Donald W. .....Peru
Ferrara, Samuel J. .....Peru
Herd, C. R. .....Peru
Johnson, Owen .....Peru
Lynn, Frank M. (H).....Peru
Malouf, Stephen D. .....Peru
Wildman, Roscoe E. .....Peru
Yarling, John E. (H) .....Peru

MONROE COUNTY

(See Owen-Monroe)

MONTGOMERY COUNTY

Crawfordsville

Burks, Jess Edwin
403 Ben Hur Bldg.
Cooksey, Thomas L. (H)
109½ S. Washington St.
Daugherty, Fred N..120 W. Pike St.
Dodds, Wemple ...Culver Hospital
Haller, Thomas C.
419 Ben Hur Bldg.
Kinnaman, Howard A.
206 Ben Hur Bldg.
Kirtley, James M.
416 Ben Hur Bldg.
Lingeman, Byron N.
419 Ben Hur Bldg.
Mount, Wm. M..413 Ben Hur Bldg.
Pierson, Robert H..305 E. Main St.
Pollom, Robt.....306 S. Water St.
Sharp, John L...219 Ben Hur Bldg.
Wallace, Hawthorne C.
419 Ben Hur Bldg.

Otten, Ralph E. .....Darlington
Blix, Fred M. .....Ladoga
Denny, Frank T. .....Ladoga
Davis, William.....New Market
Kindell, Hurschell D.
New Richmond
Johnson, Frank D.....Waynetown
Parker, Carl B. .....Wingate

MORGAN COUNTY

Alexander, P. M.....Martinsville
Bothwell, Camden G...Martinsville
Dutton, Hayes H.....Martinsville
Eisenberg, David A....Martinsville
Farr, James C. .....Martinsville
Gray, Leon .....Martinsville
Grimes, Jay H. .....Martinsville
Pitkin, Edward M.....Martinsville
Pitkin, McKendree C...Martinsville
Willan, Horace R.....Martinsville
Murphy, Maurice G...Morgantown
Seibel, Robert M. .....Morgantown
Comer, Charles W.....Mooresville
Comer, Jonathan E.....Mooresville
Comer, Kenneth E.....Mooresville
Karpel, Bernard .....Mooresville
VanBokkelen, Robert W.
Mooresville
Hughes, Lawrence M.....Paragon

NEWTON COUNTY

(See Jasper-Newton)

NOBLE COUNTY

Bowman, Charles M. .....Albion
Morr, John W. (H) .....Albion
Nash, Justin R. .....Albion
Sneary, Kenneth D. .....Avilla
Veazey, Wm. M. (H).....Avilla
Ettl, Edward .....Cromwell
Harlan, William L. .....Cromwell
Bryan, Robert E. .....Kendallville
Clark, Joseph H. .....Kendallville
Goodwin, Columbus B. (H)
Kendallville
Gutstein, Richard R....Kendallville
Hardy, Charles F. (H).Kendallville
Lawson, Isaac H.....Kendallville
Messer, Frank W.....Kendallville
Munk, Cleorie E.....Kendallville
Seybert, Joseph D.....Kendallville
Williams, Harold O....Kendallville
Young, Simon J. (H)..Kendallville
Harlin, Wm. L. .....Ligonier
Schutt, James B. .....Ligonier
Stultz, Quentin F.....Ligonier
Fipp, August L. .....Rome City
Pulskamp, Bertrand H.
Wolcottville
Luckey, Harold A.....Wolf Lake
Luckey, Robert C.....Wolf Lake
Roth, James R.....Wolf Lake
Switzer, Robert E.
Colo. Psychopathic Hosp., Denver
Fair, John R.
1011 Peachtree St., Augusta, Ga.

OHIO COUNTY

(See Dearborn-Ohio)

ORANGE COUNTY

Keseric, Nicholas E....French Lick
Sugarman, Benj. E....French Lick
Take, John F. (H)....French Lick
Colglazier, Granville G.....Leipsic
Baker, Robert E. (H).....Orleans
Hodgin, Philip .....Orleans
Schoolfield, Wm. E. .....Orleans
Clark, Ivan A. .....Paoli
Hammond, Keith .....Paoli
Spears, John K. .....Paoli
Teaford, Schulyer F. .....Paoli
Boyd, Clarence E.....West Baden
Miller, Henderson L....West Baden

OWEN-MONROE COUNTIES

Bloomington

Austin, Fred H. (H).110 E. 4th St.
Baxter, Neal E.....306 E. 5th St.
Borland, Raymond M.
114 N. Lincoln St.
Buckingham, Richard E.
344 College Ave.
Culmer, Walter N.
432 S. College Ave.
Dalton, Naomi L.....114 E. 7th St.
DeMotte, Russell..214 E. Kirkwood
Estes, Ambrose C..300½ E. 5th St.
Fowler, Richard R.
108 S. Washington
Geiger, Dillon D...300 E. Kirkwood
Hepner, Herman S..312 N. Walnut
Holland, Charles E.
712 N. Washington St.
Holland, Deward J.
313 N. College Ave.
Holland, Philip T....108 W. 7th St.
Karsell, William A.
306 East Kirkwood
Luzadder, John E. (H)
123½ W. 5th St.
Lyons, Robert E.....321 E. 5th St.
Marchant, Clarence H.
350 S. College
McClelland, Mary E.
420 S. Fess St.
Middleton, Thos. O...404 E. 7th St.
Miller, Mary E.....701 E. 10th St.
Myers, Burton D. (H)
424 N. Walnut St.
Owen, Abraham M.
200 S. Washington St.
Owen, Margaret A.
200 S. Washington St.
Owens, Walter L.
Student Health Ser., Ind. Univ.
Poolitson, George C.
407 N. Walnut St.
Prosser, William O. H.
1211 E. Maxwell Lane
Ramsey, Hugh S....107 E. 10th St.
Reed, William C.....307 E. 5th St.
Rogers, Otto F., Jr.
210 N. Washington St.
Rogers, Robert C. (H)
210 N. Washington St.
Ross, Ben R.....314 E. 7th St.
Schell, Harry D..114 N. Lincoln St.
Schuman, Edith B.
Indiana University
Smith, Herschel S.
218 E. Kirkwood
Smith, Rodney D. (H)
115 N. Washington St.
Spencer, Beaufort A.
114 N. Lincoln
Stangle, William J.
Bloomington Hospital
Topolgus, James N.
403 N. Walnut St.
Wilson, Talmage L.
301 E. Kirkwood

OWEN-MONROE COUNTIES

(Bloomington—Continued)

Wiltshire, James W. (H)
103 S. Lincoln St.

Yocum, Boaz (H) ..... Coal City
Smith, Paul E. ..... Ellettsville
Mitchell, George L. ..... Smithville
Brown, Marcel S. ..... Spencer
Greene, Claude D. ..... Spencer
Kay, Oran E. ..... Spencer
Schlieker, A. G. (H) ..... Spencer
Smith, Frederick R. ..... Spencer

PARKE-VERMILLION COUNTIES

Brown, Ralph E. ..... Cayuga
Darroch, Samuel ..... Cayuga
Casebeer, Paul B. ..... Clinton
Evans, Frederick ..... Clinton
Gerrish, Wakefield D. ..... Clinton
Phipps, Elwood B. ..... Clinton
Rosenfeld, Norman M. ..... Clinton
White, Isaac D. (H) ..... Clinton
Lauer, Dorothy B. ..... Dana
Myers, William C. ..... Dana
Warren, Bradford ..... Marshall
Britton, Welbon D. ..... Montezuma
Saunders, Jones L. ..... Newport
Johnson, William A. ..... Perrysville
Bloomer, Joseph R. ..... Rockville
Bloomer, Richard S. ..... Rockville
Dowell, Emil H. ..... Rockville
Harstad, Casper ..... Rockville
Merrell, Basil M. ..... Rockville
Pirkle, Hubert B.
Ind. State Sanitarium, Rockville
Staff, Robert A.
Ind. State Sanitarium, Rockville
White, Chester S. ..... Rosedale
Green, Silva Ira ..... St. Bernice
Keith, Freeman E. (H) . St. Bernice

PERRY COUNTY

Bush, Hargis R. ..... Cannelton
Coultas, Porter J. ..... Tell City
Dome, Hardin S. (H) ..... Tell City
Dukes, David ..... Tell City
Glenn, Fred C. ..... Tell City
James, Nicholas A. ..... Tell City
Lashley, Donald L. ..... Tell City
Neifert, Noel L. ..... Tell City
Snyder, Earl R. ..... Troy

PIKE COUNTY

Higgins, James L. ..... Petersburg
Kime, John T. (H) ..... Petersburg
Logan, Austin R. ..... Petersburg
Omstead, Milton ..... Petersburg
Rice, Thompson R. (H) . Petersburg
DeTar, George B. (H) .... Winslow
Miller, Lawrence R. ..... Winslow

PORTER COUNTY

Dale, Joseph W. ..... Chesterton
Griffin, Joseph P. ..... Chesterton
Hall, Thomas C. ..... Chesterton
Harless, Clarence M. ..... Chesterton
Butman, William C. ..... Hebron
Kleinman, Francis J. ..... Hebron
Dittmer, Samuel E. ..... Kouts
Brown, James C. ..... Valparaiso
Davis, Carl M. ..... Valparaiso
DeGrazia, Eugene ..... Valparaiso
DeWitt, Charles E. (H) . Valparaiso
Dittmer, Jack E. ..... Valparaiso
Douglas, Geo. R. (H) ... Valparaiso
Eades, Ralph C. ..... Valparaiso
Frank, John R. ..... Valparaiso
LaRocca, Joseph ..... Valparaiso
Loring, Mark L. ..... Valparaiso
Makovsky, Theodore ... Valparaiso
Miller, Ebbo H. ..... Valparaiso
Nash, Charles B. ..... Valparaiso
VanWinkle, Arthur J. .. Valparaiso
Vietzke, Paul C. F. ..... Valparaiso
Gordon, Joseph L. ..... Wheeler

POSEY COUNTY

Montgomery, Samuel B. (H)
Cynthiana
Ropp, Harold E. ..... New Harmony
Thompson, Lewis R. . New Harmony
Boren, Paul ..... Poseyville
Boren, Samuel W. (H) . . Poseyville
Woods, Arba L. ..... Poseyville
Challman, William B. . . Mt. Vernon
Herr, John W. ..... Mt. Vernon
Oliphant, Frank W. ..... Mt. Vernon
Ranes, John R. ..... Mt. Vernon
Vogel, L. John ..... Mt. Vernon
Williams, Frederic .... Mt. Vernon

PULASKI COUNTY

Dublin, Madeline ..... Francesville
Ives, Raymond J. ..... Francesville
Linton, Charles E. .... Medaryville
Kelsey, Arthur J. ..... Monterey
Carneal, Thomas E. ..... Winamac
Halleck, Harold J. ..... Wilnamac
McCaskey, George H. ..... Winamac
Thompson, William R. ... Winamac

PUTNAM COUNTY

Veach, Lester W. ..... Bainbridge
Veach, Richard L. ..... Bainbridge
Gray, Clyde C. ..... Cloverdale
Dettloff, Frederick .... Greencastle
Dobbs, O. R. ..... Greencastle
Fuson, Wenfred J. .... Greencastle
Gillespie, Joseph F. (H)
Greencastle
Hutcheson, Walter R. (H)
Greencastle
Johnson, James B. ..... Greencastle
Nichols, Anne Sackett . Greencastle
Parker, George F. ..... Greencastle
Rhea, Gilbert D. ..... Greencastle
Schauwecker, Cleon M. . Greencastle
Steele, Dick J. ..... Greencastle
Tennis, George T. ..... Greencastle
Tipton, William R. ..... Greencastle
Wiseman, V. Earle .... Greencastle
Gwaltney, Loral F. ..... Roachdale
Osborne, Harry S. R.R.1, Roachdale
Richards, Edgar E. .... Russellville

RANDOLPH COUNTY

Nixon, Byron ..... Farmland
White, Harvey E. ..... Farmland
Harmon, Wayne ..... Lynn
Jordan, Leo E. ..... Lynn
Martin, Charles E. ..... Lynn
Slick, Crystal R. ..... Lynn
Shallenberger, Henry R. .... Modoc
Hinchman, Jean ..... Parker
Henderson, Arvin ..... Ridgeville
Schenk, George H. ..... Ridgeville
Chambers, Leroy B. .... Union City
Gullett, Charles C. ..... Union City
Phipps, Leland K. ..... Union City
Reid, Robert W. ..... Union City
Ruby, Fred M. ..... Union City
Voisinet, Raymond A. ... Union City
Wills, Benjamin F. ..... Union City
Brenner, Ivan E. ..... Winchester
Dininger, William S. ... Winchester
Engle, Russell B. ..... Winchester
Painter, Lowell W. ..... Winchester
Robison, John S. ..... Winchester
Sparks, Paul W. ..... Winchester

RIPLEY COUNTY

Hisrich, Lloyd W. ..... Batesville
Lippoldt, Charles L. ..... Batesville
Obery, George A. ..... Batesville
Conrad, Henry W. ..... Milan
Hunter, Lowell G. ..... Milan
Warn, William J. ..... Milan
Row, George S. ..... Osgood
Smith, R. Lee ..... Osgood
McConnell, William C. .... Sunman
Hopkins, Lester H. ..... Versailles
Moran, Noel D. ..... Versailles

RUSH COUNTY

McNabb, George B. ..... Carthage
Worth, C. Willard ..... Milroy

Rushville

Atkins, C. C. ..... 225 N. Morgan
Corpe, Kenneth F. ..... Rushville
Dean, Donald I. ..... 310 E. Fifth
Denny, Melvin H. .... 125 W. Third
Ellis, Davis W. . . 4th and Main Sts.
Green, Frank, Jr. .... 132 E. Second
Johnson, Robt. B. . . . 229 N. Morgan
Kennedy, Robt. O. .... 118 W. Third
Nutter, W. H. ..... 205 W. Third
Truman, Elmer M. . . 733 N. Morgan
Shanks, Roy E. ..... I.O.O.F. Bldg.

ST. JOSEPH COUNTY

Houser, D. Stanley ..... Lakeville
How, John T. (H) ..... Lakeville

Mishawaka

Barone, C. V. . . . 312 Lincolnway W.
Bassler, C. R. . Mishawaka Tr. Bldg.
Christophel, Verna . . . 109 W. Third
Ganser, Richard A.
114 Lincolnway W.
Goethals, C. J. . . 602 Lincolnway W.
Joest, Charles O. .... 113 S. Church
Logan, Francis W.
208 First Nat. Bk. Bldg.
Orr, Robert ..... 124 S. Race
Rosenwasser, Jacob
225 Lincolnway East
Sirlin, Edw. M. ..... 111 S. Church
Spalding, Wendell L.
212 First Nat. Bk. Bldg.
Templeton, A. R. . 914 W. Lawrence
Van Rie, Leo P. ..... 116 S. West

ST. JOSEPH COUNTY

(Mishawaka—Continued)

Walters, Charles . . 206 Polis Bldg.
Ward, Jas. W. . . 316 Lincolnway W.
Whitlock, Merle E. . 123 W. Fourth
Wixted, Jno. F. . 114 Lincolnway W.
Wixted, Julia F.
114 Lincolnway, W.
Wurster, Herbert C. . . 221 E. Third
Wygant, Marion D. . . 116 W. Third
Wyland, Byron J. . . 116 W. Third
Zimmer, H. J. . 119½ Lincolnway W.

Luzadder, John E., Jr. New Carlisle
Hardy, John J. . . . . North Liberty
Warrick, Homer Lyle . . . . . Osceola

South Bend

A

Abel, Joseph A. . 1222 Western Ave.
Acker, Robert B.
418 Sherland Bldg.
Arisman, Ralph K.
711 Odd Fellow Bldg.

B

Balla, Morris . . . 404 Sherland Bldg.
Bartsch, Harvey L.
1909 S. Michigan St.
Bechtold, Samuel E.
730 Sherland Bldg.
Bennett, Jene R. . . . . 531 Main St.
Bergan, Joseph A. . . . 828 E. Colfax
Berke, Robert D. . 1721 East Ewing
Biasini, Benedict A.
401 Dixie Way North
Bickel, David A.
515 Odd Fellows Bldg.
Birmingham, Peter J.
426 Sherland Bldg.
Bishop, Charles A.
122 N. Lafayette Blvd.
Bixler, Louis C. 615 Sherland Bldg.
Blackburn, Erwin
508 Sherland Bldg.
Bodnar, Leslie M.
215 Poledon Bldg.
Bolka, Bernard . . . . . 728 W. Colfax
Borough, L. D. . . . . 514 J.M.S. Bldg.
Bryan, Robert J.
1002 Lincolnway W.
Buchanan, Wallace D.
825 Sherland Bldg.
Buechner, Frederick W.
116 N. Main St.
Bussard, Clifford F.
634 Associates Bldg.
Bussard, Frank
634 Assoriates Bldg.

C

Carter, F. R. N. 605 Sherland Bldg.
Cassady, James V.
525 Sherland Bldg.
Caton, Joseph R.
502 J.M.S. Bldg.
Chambers, William
822 Sherland Bldg.
Clapp, Fred R.
122 N. Lafayette Blvd.
Clark, Stanley A.
1242 E. Jefferson St.
Clark, William H.
122 N. Lafayette Blvd.
Colip, George D.
514 Sherland Bldg.
Condit, David H.
122 N. Lafayette Blvd.
Cook, Gordon C.
122 N. Lafayette Blvd.
Cooper, Harry L.
410 Sherland Bldg.
Culbertson, Carl S. . 531 N. Main St.
Custer, Edward W.
Healthwin Sanitarium

D

Denham, Robert H.
425 Odd Fellows Bldg.
Dietl, Ernest L. 527 Sherland Bldg.
Dodd, Robert D. . 759 Portage Ave.
Donnelly, Everett F.
730 W. Indiana Ave.
Duggan, James A.
316 St. Joseph Bank Bldg.
Dunlap, D. Logan . 716 J.M.S. Bldg.

E

Edwards, Bernard E.
226 Sherland Bldg.
Egan, Sherman 301 Sherland Bldg.
Ellison, Alfred . 826 Sherland Bldg.
English, John P.
122 N. Lafayette Blvd.
Ericksen, Lester G.
615 Sherland Bldg.

F

Faltin, Ladislaus
609 Odd Fellows Bldg.
Feldman, Max . . . . . 1921 Miami St.
Filipek, Walter J.
311 Odd Fellows Bldg.
Firestein, Ben Z. . . 730 J.M.S. Bldg.
Firestein, Ray
3201 Mishawaka Ave.
Fish, Clyde M. . . 723 Sherland Bldg.
Fish, Edson C.
401 N. Notre Dame Ave.
Fisher, Lawrence F.
825 Sherland Bldg.
Frank, Lyall L. . . . 534 N. Lafayette
Frash, DeVon W. . . 306 J.M.S. Bldg.
Frey William B. . 209 Poledor Bldg.
Friedman, Morris S.
218 Poledor Bldg.
Frith, Gladys
521 W. Washington Ave.
Frith, Louis G.
521 W. Washington Ave.

G

Gates, George E.
122 N. Lafayette Blvd.
Gilman, Marcus M.
403 Odd Fellow Bldg.
Giordano, Alfred S.
531 N. Main St.
Goraczewski, Thaddeus C.
1016 W. Washington Ave.
Gordon, J. M. . . . . 726 J.M.S. Bldg
Green, G. F. . . . 822 Sherland Bldg.
Green, Norval E. . . . . Poledor Bldg.
Grillo, Donald . . 530 Sherland Bldg.

H

Haley, Paul E. . . 401 Sherland Bldg.
Hamilton, Chas. D. . . . 814 Turnock
Harmon, V. E. . . 302 Sherland Bldg.
Haugseth, Ellsworth K.
122 Lafayette Blvd.
Helmen, H. W. . . 120 Franklin Place
Hewitt, M. I. . . . 301 Sherland Bldg.
Hilbert, J. W. . 401 W. Washington
Hillman, M. W. . 429 Sherland Bldg.
Hillman, W. H. (H)
429 Sherland Bldg.
Hoffman, Robert V., Jr.
531 N. Main St.
Hoffman, R. V. . 416 Sherland Bldg.
Holdeman, L. S. . . 404 N. Lafayette
Holdeman, R. W. . 404 N. Lafayette
How, Louis E. . . . 6107 S. Michigan
Huffman, A. D. . . 1807 Portage Ave.
Hyde, C. C. . . . . 122 N. Lafayette
Johns, N. C. . . 1329 N. St. Joseph St.

K

Kamm, B. A. . . . 526 Sherland Bldg.
Karn, John . . . . 728 W. Colfax Ave.
Kim, Chang Ha . . . Healthwin Hosp.
Klahr, E. E. . . 706 Odd Fellow Bldg.
Knapp, Arthur L. . 2215 Mishawaka
Knode, K. T. . . . . 729 Sherland Bldg.
Kramer, Albert A. . . . . 1519 Miami
Kuhn, F. L. . . . . 1215 S. Michigan

L

Lane, William H. . . . . 604 N. Main
Lang, Joseph E. . . 730 J.M.S. Bldg.
Langenbahn, Carl J.
206 Sherland Bldg.
Lionberger, John R.
615 Sherland Bldg.
Liss, E. C. . . . 317 Odd Fellow Bldg.
Ludwick, H. . . 2730 Lincolnway W.
Luthy, Karl R. . . . . 1204 E. Bronson

M

Mason, Bernard A.
122 N. Lafayette Blvd.
McCraley, W. J. . 406 Sherland Bldg.
McDonald, R. M. . . 410 J.M.S. Bldg.
McFarland, Corley B.
122 N. Lafayette Blvd.
McKenna, H. J. . . . . 1615 E. Wayne
McMeel, J. E. . 612 Associates Bldg.
Metcalfe, Grant E.
319 Odd Fellow Bldg.
Mikesch, W. H. . 816 Sherland Bldg.
Miller, Milo K.
122 N. Lafayette Blvd.
Miller, W. E. . . . 714 W. Washington
Mohler, Floyd W. . . Childrens Hosp.
Mott, C. A. . 1301½ W. Washington
Murphy, Eugene C.
122 N. Lafayette Blvd.
Murphy, J. F. . . . . 625 J.M.S. Bldg.

N

Nelson, F. Dale . 428 Sherland Bldg.
Nelson, R. E. . . 510 Sherland Bldg.
Olney, T. A. (H) . Country Club Rd.
Olson, K. L. . . . . 615 Sherland Bldg.

P

Parke, D. Davis . . . St. Joseph Hosp.
Pauszek, T. B. . 726 W. Washington
Petrass, A. . . . . 516 Sherland Bldg.
Plain, G. . . . 122 N. Lafayette Blvd.
Proudfit, Charles H.
525 Odd Fellow Bldg.
Pyle, H. D. . . . . 518 Sherland Bldg.

ST. JOSEPH COUNTY

(South Bend—Continued)

R

Rasmussen, Ruth F. 122 N. Lafayette Blvd.
Rigley, E. L. . . . .408 Sherland Bldg.
Rodin, H. H. . . . .422 Sherland Bldg.
Rosenheimer, G. M. . . . .604 N. Main
Rowdabaugh, Marshall J. 1428 E. Wall St.
Rubens, Eli . . .201 Christman Bldg.
Rudicel, Max . . . . . .531 N. Main St.
Rudolph, Carl J. . . .617 J.M.S. Bldg.

S

Sanderson, Robert B. 730 Sherland Bldg.
Sandock, I. . . .402 Sherland Bldg.
Sandock, Louis F. . .406 Platt Bldg.
Sandoz, Harry H. 615 Odd Fellow Bldg.
Sandoz, L. A. . . .720 Sherland Bldg.
Savery, C. E. . . .230 Sherland Bldg.
Schiller, H. A. .510 Sherland Bldg.
Scott, F. M. .122 N. Lafayette Blvd.
Selby, Keith E. .407 Lincolnway W.
Sennett, C. M. .318 Sherland Bldg.
Sensenich, R. L. . . .203 J.M.S. Bldg.
Shelley, Edw. . . .302 Sherland Bldg.
Skillern, P. G. .1002 Bldg. & Ln. Tr.
Slominski, Harry H 708 Odd Fellow Bldg.
Spenner, R. W. .726 Sherland Bldg.
Staunton, H. A. . .3023½ Mishawaka
Stiver, D. D. . . . 822 Sherland Bldg.
Stratigos, Joseph S. 713 E. Jefferson Blvd.

T

Thompson, John M. 527 Sherland Bldg.
Thompson, Robert A. 730 W. Indiana Ave.
Thornton, M. J. .825 Sherland Bldg.
Traver, P. C. . . . .1010 Riverside Dr.

V-W

Vagner, S. Bernard 1303½ W. Washington
Wegner, W. C. (H) . .616 W. Wash.
Weiss, Eugene . . .2521 S. Michigan
Wilhelm, A. M. .628 Sherland Bldg.
Wilson, James . . . .409 J.M.S. Bldg.
Zeiger, Irvin . . . . . .3201 Mishawaka

Linton, Charles D. . . . . .Walkerton
Nassef, George J. . . . . .Walkerton
Cline, Kenneth L. . . . . .Wyatt
Brechtel, Harvey J. Naval Dispensary, Green Cave Springs, Fla.

SCOTT COUNTY

Bogardus, Carl R. . . . . .Austin
Hill, Thomas N. . . . . .Scottsburg
McClain, Marvin L. . . . .Scottsburg
Napper, Floyd S. . . . . .Scottsburg

SHELBY COUNTY

Nigh, Rufus M. . . . . .Fairland
Davis, John A. . . . . .Flat Rock
Nave, H. E. . . . . .Fountaintown
Miller, Frank H. . . . . .Morristown
Patten, Vernon C. (H) .Morristown

Shelbyville

Barnum, Emerson .Methodist Bldg.
Billman, Gustus S. . . . . .R. R. 2
Coomes, M. Joseph (H) .Shelbyville
Gehres, Robert W. .15 S. Tompkins
Inlow, H. H. . . .103 W. Washington
Inlow, W. D. . . .103 W. Washington
Miller, Richard C. . . . . .17 Mechanic
Richard, N. F. .103 W. Washington
Scott, C. C. . . . .103 W. Washington
Scott, V. B. . . . .103 W. Washington
Silbert, David B. . . . . .Pitman Bldg.
Spindler, Robt. D. .165 W. Mechanic
Tindall, Paul R. . . . . .20 N. Pike
Tindall, W. R. . . . . .505 S. Harrison
Whitcomb, Roger F. 302 Methodist Bldg.
Wiley, William M. . . . . .Shelbyville

Coulson, Sewell B. . . . . .Waldron
Keeling, James E. (H) . . . .Waldron
Fodor, Oscar . . .5306 E. 180th St., Seattle 55, Wash.

SPENCER COUNTY

Lomax, Claude C. . . . . .Dale

STARKE COUNTY

Ferguson, John T. . . . . .Hamlet
DeNaut, James F. . . . . .Knox
Henry, Howard S. . . . . .Knox
Ingwell, Guy B. . . . . .Knox
Farabee, Charles R. . .North Judson
Matthew, J. R. . . . . .North Judson

STEUBEN COUNTY

Barton, Robert . . . . . .Angola
Creel, Donald W. . . . . .Angola
Crum, Marion M. . . . . .Angola
Hartman, John J. . . . . .Angola
Kissinger, Knight L. . . . . .Angola
Lane, William H. (H) . . . . . .Angola
Mason, Donald G. . . . . .Angola
Rausch, Norman W. . . . . .Angola
Blosser, Blaine A. . . . . .Fremont
Alford, James . . . . . .Hamilton
Denman, Robert D. . . . . .Helmer

SULLIVAN COUNTY

Brown, John S. . . . . .Carlisle
Whipps, Charles E. . . . . .Carlisle
Dukes, Betty . . . . . .Dugger
Dukes, Frederic M. . . . . .Dugger
Dukes, Joe E. . . . . .Dugger
Bland, Herbert E. (H) . .Fairbanks
Butler, John O. . . . . .Farmersburg
O'Dell, Harry C. . . . . .Farmersburg
Oliphant, Jacob T. . . .Farmersburg
Hamilton, Antha Ann . . . .Shelburn
Bedwell, Marion H. . . . . .Sullivan
Briggs, Carl F. . . . . .Sullivan
Crowder, James H., Jr. . . . .Sullivan
Maple, James B. . . . . .Sullivan
Scott, Garland D. . . . . .Sullivan
Scott, Irvin H. . . . . .Sullivan
Donnelley, Robert W. St. Luke's Hosp., Chicago, Ill.
O'Dell, Harry W. Cleveland Clinic, Cleveland, O.

SWITZERLAND COUNTY

Bear, Lowery H. (H) . . . . . .Vevay
Copeland, Geo. W. (H) . . . . . .Vevay
Ellerbrook, George E. . . . . .Vevay
Griffith, Harold . . . . . .Vevay

TIPPECANOE COUNTY

Wagoner, John B. . . . . .Colburn
Wagoner, Robert H. (H) . .Colburn

Lafayette

Ade, C. H. . . . .Lafayette Life Bldg.
Ade, Mary K. .Lafayette Life Bldg.
Arnett, Arett C. . . . . .312 N. Eighth
Balkema, C. M. . . . 31 N. Twentieth
Bauer, Arthur J. . . .112 N. Seventh
Bayley, R. H. M. . . . .312 N. Eighth
Bayley, William E. .Home Hospital
Beeler, James M. Wabash Valley Sanitarium
Buhrmester, Harry C., Jr. 312 N. Eighth
Burkle, John C. . . . . .133 N. Fourth
Burns, Kendall R. St. Elizabeth Hospital
Calvert, Raymond R. . .314 N. Sixth
Cole, Ira . . . . . .2315 South
Coloviras, George, Jr. St. Elizabeth Hospital
Cox, Wayne T. 206-7 Schultz Bldg.
Coyner, Alfred B. 815-16 Lafayette Life Bldg.
Crockett, Franklin S. 724 Lafayette Life Bldg.
Currie, R. W. . .St. Elizabeth Hosp.
Dewey, G. W. (H) . .Soldiers Home
Donahue, George R. Lafayette Life Bldg.
Dubois, Ramon B. . . . . .516 Main
Eaton, M. J. . .Lafayette Life Bldg.
Engeler, James E. . . .308 N. Eighth
Ferguson, Wm. B. . . .24 N. 24th St.
Flack, Russell A. . . . .217 N. Sixth
Frasch, M. G. .Lafayette Life Bldg.
Frey, Harley B. 405 Lafayette Life Bldg.
Gery, Richard E. . . .312 N. Eighth
Graham, T. G. .11 N. Twenty-fourth
Harshman, M. L. . . .312 N. Eighth
Harter, Eli Blair . . .312 N. Eighth
Herrold, George W. Lafayette Life Bldg.
Holladay, Lloyd J. Lafayette Life Bldg.
Hughes, Richard . . .2216 South St.
Hunsberger, W. G. . .312 N. Eighth
Hunter, F. P. .Lafayette Life Bldg.
Hupe, Charles (H) . .212 N. Eighth
Ikins, Ray G. . . . . .605 S. Seventh
Johnson, Herbert S. . .312 N. 8th St.
Jones, David . .24 N. Twenty-fourth
Johnson, Lowell R. . . . . .2315 South
Karberg, R. J. . .15 N. Twenty-fifth
Klepinger, Harry E. 824 Lafayette Life Bldg.
Laws, H. J. . . .Lafayette Life Bldg.
Laws, Kenneth F. 501 Lafayette Life Bldg.
Loop, Floyd A. Lafayette Life Bldg.
Loop, F. A. . . .Lafayette Life Bldg.
McAdams, H. B. . .631 Columbia St.
McClelland, D. C. . . .312 N. Eighth
McFadden, James M. St. Elizabeth Hosp.

TIPPECANOE COUNTY

(Lafayette—Continued)

McKinney, Daniel H.
Lafayette Life Bldg.
Marsh, G. W. . . 1405 N. Fourteenth
Martin, H. G. . . . . 417 Ferry
Martin, Joe M. . . . . 417 Ferry
Miller, Roland E. . . . . 1625 Kossuth
Morrison, John S. (H)
Lafayette Life Bldg.
Neumann, Kenneth O.
613 Lafayette Life Bldg.
Pearlman, Samuel S. . . 107 N. Sixth
Peterson, Joel A.
609 Lafayette Life Bldg.
Peyton, Frank W. . . . . 15 N. 25th
Ratcliff, Frank W. . . . . 300 Main
Romberger, Floyd T.
405 Lafayette Life Bldg.
Rothrock, Philip W. . . 1625 Kossuth
Ruschli, Edward B.
Lafayette Life Bldg.
Shafer, John W. (H) . . 619 Kossuth
Sholty, William M.
405 Lafayette Life Bldg.
Smith, Lowell C. . 405 Schultz Bldg.
Stahl, Edward T. . . . 312 N. Eighth
Strayer, Joseph W.
612 Lafayette Life Bldg.
Strickland, Martha B. . 114 Wells St.
Thomas, Gordon A. . 608 Columbia
Trout, Carl J. . . . . 314 N. Sixth
Tubbs, George R. . . . . 608 Columbia
VanBuskirk, E. L. . . . 308 N. Eighth
Vermilya, Robert W.
Lafayette Life Bldg.
Waite, Richard R. . . . . 115 S. Sixth
Washburn, Will W. . . 312 N. Eighth

Mitchell, Edgar T. . . . . Romney
Babb, Forrest J. . . . . Stockwell

West Lafayette

Ash, Harold H. . . . . 225 State
Harden, Murray E.
610 Carrollton Blvd.
Meikle, Louise J. . . . 606 Ferry Lane
Miller, Sayers J. . . . . Purdue Univ.
Rommel, C. H. . . 460 Northwestern
Rose, Bertha . . . . . Purdue Univ.
Spurlock, Fae H. . 214 Northwestern

TIPTON COUNTY

Cotton, Stanley M. . . . . Goldsmith
Dunham, Wilbur F. . . . . Kempton
Stouder, Albert E. . . . . Kempton
Tranter, William F. . . . . Sharpsville
Burkhardt, Boyd A. . . . . Tipton
Carter, Jean V. . . . . Tipton
Compton, George . . . . . Tipton
Gossard, Meredith B. . . . . Tipton
Kurtz, William A. . . . . Tipton
Overman, Frederick V. . . . . Tipton
Warne, George H. . . . . Tipton
Ericson, Harold L. . . . . Windfall
Moser, Elmer B. . . . . Windfall

UNION COUNTY

(See Wayne-Union)

VANDERBURGH COUNTY

Evansville

A

Acre, Robert R. . . 617 Hulman Bldg.
Adler, Raymond N. . . . . 714 Second
Alexander, John E.
609 Hulman Bldg.
Anderson, Dwight W. . 814 N. Main
Antes, Earl H. . . . . 412 SE Fourth
Austin, E. W. . 216 SE Riverside Dr.

B

Baker, H. M. . . . . 402 Hulman Bldg.
Baker, Jas. S. . . 407 Metro Bk. Bldg.
Ballas, William A. . . . 1558 Marshall
Barclay, Irvin C. . . . . 114 SE Second
Barnhart, Willard T. . 527 Sycamore
Baylor, Edward M. . . 415 S. Lincoln
Beeler, Bruce H.
709 S. Kentucky Ave.
Bennett, Abner
Welborn Baptist Hospital
Boswell, R. W. C. . . . . 2509 Wash.
Boyd, Stella N. . 502 Hulman Bldg.
Brockmole, A. W. . . . . 700 Mary St.
Brown, R. L. . . . . 629½ Main St.
Brown, J. A., Jr. . . . . 605 E. Sixth
Browne, W. A. . . Court Hse. Annex
Bryan, S. L. . . . . 902 Hulman Bldg.
Buchholz, R. R. . . . . 412 SE Fourth
Buikstra, C. R. . 609 Hulman Bldg.
Burnikel, Ray H. . . . . 221 Chestnut

C

Cacia, John J. . . . 609 Hulman Bldg.
Caldwell, W. C. . . 504 Old Nat. Bk.
Clements, Albert F. . . 15 SE Second
Clouse, Paul A. . . . . 121 Edgar St.
Cockrum, W. M. . 908 Hulman Bldg.
Cody, Burtis L. . . 204 Boehne Bldg.
Coleman, Joseph E.
216 SE Riverside Dr.
Combs, H. T. . . . . 807 W. Indiana
Combs, Jno. H. . . . . 412 SE Fourth
Combs, Pearl B. . . . . 1623 Lincoln
Corcoran, P. J. V. . . . . 118 S. First
Crawford, Jas. H. . . . . 221 Chestnut
Crevello, Albert J.
Clearview Hosp., Kratzville Rd.
Crimm, Paul D. . . . . Boehne Hosp.
Cullnane, C. W. . . 2312 W. Franklin

D

Daves, William L.
608 Old Nat. Bk. Bldg.
Denzer, Edw. K. . . . . 108 SE Second
Denzer, Wm. O. . . . . 108 SE Second
Dieckman, H. S. 1012 Cit. Bk. Bldg.
Diefendorf, Charles F.
2106B W. Franklin
Dodd, Roberts K. . . 819 W. Franklin
Durkee, Melvin S.
403 Citizens Nat. Bk. Bldg.
Dycus, Walter A.
319 N. St. Joseph Ave.
Dyer, W. K. . . . . 910 Hulman Bldg.

E

Ehrich, William S.
808 Old Nat. Bk. Bldg.
Eisterhold, J. A. . . 220 SE Riverside
Engel, Edgar L. . . . . 15 SE Seventh

F

Faul, Henry J. . . 815 Hulman Bldg
Fickas, Dallas . . . . . 619 Mary St.
Fisher, Wm. C. . . . . 413 First Ave.
Fitzsimmons, E. L. . 527 Sycamore
Flinn, J. H. . . . . 221 Chestnut St.
French, Wm. G. . . . Sta. D, Box 2006
Friedman, Leo . . . . . 9 Main
Fritsch, Louis E. . . . . 1201 First

G

Garland, Edgar A. 606 S. Weinbach
Gaul, L. Edw. . . . 509 Hulman Bldg.
Gill, Bernard P. . . . 113½ NW Fifth
Griep, Arthur H. . . . 412 SE Fourth

H

Hammond, R. Case . 629½ Main St.
Hare, Daniel M. . 617 Hulman Bldg.
Hare, John H. . Evansville St. Hosp.
Harris, Wm. Lee . . . . 115 SE 6th St.
Hartley, C. A., Jr. . . . . 221 Chestnut
Hartz, F. Minton . . . . 123 SE Second
Heard, Albert . . . . . 322 E. Cherry
Heberer, Jos. M. . 1111 W. Columbia
Hefti, Karl R. . . . . 125 SE Second
Heinrich, Weston A. . . 1308 N. Main
Helper, Morton . . . . . 219 Walnut
Herzer, Clarence C. . . 322 N. Fulton
Hobbs, Arthur
Protestant Deaconess Hosp.
Hoopes, Jane M. . . . 125 SE Second
Huggins, Victor S.
703 Citizens Nat. Bk. Bldg.
Hyatt, Gilbert T. . . . 412 SE Fourth

J

Johnson, G. C. (H)
212 Am. Tr. Bldg.
Johnson, Stephen L. . . 521 Sycamore

K

Kauffman, Harley M. 219 Walnut
Kessler, Robt. B. . . 1003 First Ave.
Kiechle, F. L. . . . . Boehne Hosp.
King, Everett A. . . . . 208½ Main
Kirch, Leo N. . . 912 Hulman Bldg.
Kleindorfer, R. L. . 819 W. Franklin

L

Lang, Shirley C. . . 957 S. Kentucky
Laubscher, Clarence . Kratzville Rd.
Lawrence, Jos. C. . . . 413 First Ave.
Leich, Chas. F. . . . . 124 SE First
Leslie, Ermil T. . . . . 122 Locust
Logan, Jesse R. . . . . 503 First Ave.
Lynch, Harold D. . 216 SE Riverside
Lynch, Paul V. . . . 216 SE Riverside

M

McCool, Joe H. . . . . 1308 N. Main
McCool, William E. (H)
R. R. 5, Camp Ground Rd.
Macer, C. G. . . . . 411 Hulman Bldg.
MacKenzie, Pierce . . 15 SE Seventh
Mason, E. E. . . . . 906 Hulman Bldg.
Mehl, Rudolph A. . . . . 752 S. Eighth
Meyer, Keith T. . . . . 118 SE First
Miller, Laverne B. . . . . 714 N. Main
Miller, Milton . . . . . 103 N. Main
Miller, Minor . . . . Court Hse. Annex
Miller, Robert J. . . . . 1905 Division
Mills, Fred E. . . . . Deaconess Hosp.
Mino, Victor H. . . . . 723 Mary

VANDERBURGH COUNTY

(Evansville—Continued)

Moehlenkamp, Charles E. 614 N. Governor
Muelchi, A. F....518 Hulman Bldg.

N

Nenneker, Henry (H) Harmonyway
Neucks, H. C.....207 SE First St.
Newman, A. E...912 Hulman Bldg.
Niedermayer, Alfred J. Welborn Baptist Mem. Hosp.
Nisenbaum, Harold 704 Hulman Bldg.

O

Oppenheimer, Ernst.103 SE Second

P

Pastor, Julius W.....5206 Lincoln
Pollard, Walter S...115 SE Second
Porro, Francis W..St. Marys Hosp.
Present, Julian .....6 SE Second
Pugh, Willis .....413 First

R

Raphael, I. J.....617 Hulman Bldg.
Ratcliffe, A. W.....510 SE First
Ravdin, B. D.....712 Hulman Bldg.
Ravdin, M. (H)..712 Hulman Bldg.
Reich, Clarence E...1209 N. Fulton
Reitz, Thos. F.....700 N. Sixth
Rininger, H. C....1359 Washington
Ritz, Albert S.....2605 Lincoln
Robinson, Earl U...615 Bellemeade
Rosenblatt, B. B..709 Hulman Bldg.
Rossow, Russell .....118 SE First
Royster, G. M....810 Cit. Bk. Bldg.
Royster, R. A....810 Cit. Bk. Bldg.
Ruddick, H. C...816 Hulman Bldg.
Rusche, Henry J.....701 Harriet
Russell, Richard H. St. Mary's Hospital

S

Schirmer, R. H...1118 W. Franklin
Schneider, Charles P. 2211 W. Franklin St.
Schriefer, Victor V. 1307 Stringtown Rd.
Slaughter, H. C..908 Hulman Bldg.
Slaughter, John..808 Cit. Bk. Bldg.
Slaughter, O. L.....118 E. First
Snively, W. D., Jr. Mead Johnson & Co.
Springstun, Walter R. 601 Hulman Bldg.
Steele, Paul W.....629½ Main St.
Stork, Urban.....412 SE Fourth
Sterne, John ....308 Wright Bldg.
Sutter, Chas. C...1311 Cumberland

T

Taylor, Eugene C.....853 Lincoln
Tilden, Margaret 200 S. Parker Dr.
Tweedall, D. C....527 Sycamore St.
Tweedall, D. G...2114 W. Franklin

U-V

Underwood, Gordon B. 509 Hulman Bldg.
Viehe, Robt. W.....207 SE First
Visher, J. S..805 Old Nat. Bk. Bldg.
Visher, John W. 805 Old Nat. Bk. Bldg.

W

Weber, Edgar H....123 SE Second
Weiss, Henry G..614 Hulman Bldg.
Welborn, Mell B....412 SE Fourth
Wesson, Thos. W.....124 SE First
Wilhelmus, C. Kenneth 115 SE 7th St.
Wilhelmus, Gilbert.....1028 Wash.
Wilhelmus, Wm. M.....R. R. 7
Willis, Chas. F.....1100 S. Bedford
Willison, G. W.....118 SE First
Wilson, J. D.....1207 E. Park Dr.
Wilson, Ralph .....517 Mary
Wishart, Shelby W. 416 3rd & Main Bldg.
Wood, Wm. H....1651½ Lincoln Av.
Woods, Wm. P.....15 SE Seventh
Wynn, J. F.....906 Hulman Bldg.

X-Y-Z

Yeck, Charles W.....115 SE Sixth
Yunker, Philip E.....116 Mulberry
Zimmerman, Harold..6 SE Second

Coffman, Delmer Lee Western Okla. T. B. Hosp., Clinton, Okla.
Hart, L. Paul....1454 Coolidge Dr., University City, Mo.
McDonald, Jos. D....1463 Coolidge, University City, Mo.
Wyatt, Fred H....1301 Garfield St., Denver, Colo.

VERMILLION COUNTY

(See Parke-Vermillion)

VIGO COUNTY

Loving, Jury B.....New Goshen
McIntosh, Wilbert .....Riley
Carmichael, Clyde S.....Seelyville

Terre Haute

A

Agee, Ernest B., Jr....221 S. Sixth
Alexander, Oliver O. 301 Rose Disp. Bldg.
Allen, O. T....422 Rose Disp. Bldg.
Anderson, W. C.....721 Wabash
Asbury, W. D..322 Rose Disp. Bldg.
Ault, Roy, Jr.....Tribune Bldg

B

Baldridge, William O. 12 Points State Bk. Bldg.
Blum, Leon L.....721 Wabash
Bopp, Henry W. 521 Grand Opera Hse. Blg.
Bopp, James.....521 Opera Bldg.
Bradley, Stephen C....221 S. Sixth
Bronson, Paul J.....721 Wabash
Brown, Robert R.....221 S. Sixth

C

Cajacob, Melville E...1000 S. Sixth
Carpenter, George C.....410 Ohio
Cavins, Alexander W..221 S. Sixth
Combs, Chas. N.....2516 N. Ninth
Combs, S. R.....505 Tribune Bldg.
Congleton, George C. 308 Merchants Nat. Bk. Bldg.
Conklin, J. O..500 Rose Disp. Bldg.
Connelly, Jno. J...Rose Disp. Bldg.
Crawford, Theo. R.....221 S. Sixth
Curry, C. A...506 Rose Disp. Bldg.

D

Dailey, John E.....1230 Wabash
Decker, Harvey B....202 Rea Bldg.
Dorsey, Philip W....Tribune Bldg.
Dyer, Geo. W..208 Rose Disp. Bldg.

E

Edmondson, R. E....2201 S. Center
Eisenlohr, Eugen .....128 S. Sixth

F

Forsyth, David H. 215 Merchants Nat. Bk. Bldg.
Freed, J. E...414 Rose Disp. Bldg.
Freed, John E., Jr. 414 Rose Disp. Bldg.
Fuqua, H. B.....Rose Disp. Bldg.

G

Gerrish, D. A.....Rose Disp. Bldg.
Gilbert, Ivan.505 Rose Disp. Bldg.
Gillum, John R.....221 S. Sixth
Goodman, Hubert T. 310 Opera House Bldg.
Gossom, Donn R...Rose Disp. Bldg.

H

Harkness, Robert G. 301 Rose Disp. Bldg.
Haslem, E. R..401 Rose Disp. Bldg.
Haslem, John R.....221 S. Sixth
Hoover, Dewey A. ...14½ N. Third
Hoover, Jas. J.....14½ N. Third
Humphrey, Paul E. 322 Rose Disp. Bldg.
Hunt, Edgar J.....R. R. 1

J

Johnson, Paul D.....822 N. 15th

K

Kabel, Robert N.....Tribune Bldg.
Krieble, William W....221 S. Sixth
Kunkler, Joseph .....408 Chestnut
Kunkler, William C. 212 Merchants Bk. Bldg.

L

LaBier, Clarence Rollin (H) 408 Rose Disp. Bldg.
LaBier, C. R...408 Rose Disp. Bldg.
Lancet, Robert O.....2022 Wabash
Lee, Allen H.....502 Tribune Bldg.
Loewenstein, W. L..1421 S. Seventh
Love, John R.....1601 Eighth Ave.
Luckett, C. L..211 Fairbanks Bldg.

M

McBride, Noel S. 407 Merchants Nat. Bk. Bldg.
McCormick, Wilbur C. 312 Merchants Bk. Bldg.
McEwen, James W. 321 Rose Disp. Bldg.

VIGO COUNTY

(Terre Haute—Continued)

McLaughlin, Gordon C.
501 Tribune Bldg.
Mahoney, Charles L...221 S. Sixth
Malone, Leander A.....721 Wabash
Mason, Lester M.
312 Merchants Nat. Bk. Bldg.
Mattox, Don M.....721 Wabash
Meyn, Werner P.....221 S. Sixth
Miklozek, John E...1461 S. Seventh
Miller, Daniel B....1603 S. Seventh
Mitchell, A. M...503 Tribune Bldg.
Mohr, Ann L. M.....R. R. 1,
West Terre Haute
Musselman, G. G...2257 Fifth Ave.

N-O

Nay, Ernest O.....221 S. Sixth
Oliphant, R. W..410 Tribune Bldg.

P

Pearce, Roy V.....1440 S. 25th St.
Pierce, Harold J.....627 Cherry

R

Reed, Robert C..211 Fairbanks Bld.
Reynolds, Richard J....901 S. 25th
Richart, J. V..414 Rose Disp. Bldg.
Riggs, Floyd C.
Indiana State Teachers College
Rubin, Milton M.....Tribune Bldg.

S

Sayers, F. E...507 Rose Disp. Bldg.
Scherb, Burton E...104 N. Seventh
Schott, Edward J.
Merchants Nat. Bk. Bldg.
Schumaker, Robert A.
211 Fairbanks Bldg.
Selsam, Etta
203 Merchants Nat. Bk. Bldg.
Shanklin, Vernon A.
208 Fairbanks Bldg.
Showalter, J. R....1255½ Maple Rd.
Siebenmorgen, L....1200 S. Eighth
Siebenmorgen, P....1200 S. Eighth
Siegman, Edwin L.....627 Cherry
Silverman, N. M...1634 S. Seventh
Sloss, Imit H.....1029 S. Seventh
Smoots, S. A.....1307 Maple Ave.
Speas, R. C.....402 Tribune Bldg.
Spigler, James F.
314 Merchants Nat. Bk. Bldg.
Stewart, Walter E.....721 Wabash
Stoelting, J. L.507 Rose Disp. Bldg.
Strecker, Wm. L.....2250 Wabash
Strong, Daniel S....R.R. 7, Box 170
Sullivan, John M.....907 College

T

Topping, M. C...505 Tribune Bldg.

U-V

Utterback, Arnold
603 Merchants Nat. Bk. Bldg.
VanArsdall, C. R.....17 S. Ninth
Vandivier, Henry R. (H)
210 Rose Disp. Bldg.
Voges, Edward C.....1402 Wabash

W

Weber, Joseph G. S....721 Wabash
Weinstein, Joseph H...221 S. Sixth
White, Jas. V.....Tribune Bldg.
Wiedemann, Frank E. (H)
222 Rose Disp. Bldg.
Wilkerson, Edw. L....6½ N. Fourth
Wilson, Fred L.....1501 S. Third
Wyeth, Chas. (H) 1100 S. Seventh

X-Y-Z

Yung, J. R....501 Rose Disp. Bldg.
Zwerner, Paul F.
12 Points State Bk. Bldg.

Cabell, Abram L. (H)
1751 Dumesine, Louisville, Ky.
Day, Theodore P..832 Waverly Rd.,
Willoughby, Ohio
Niblack, Earl S. (H)
136 N. Woods Rd.,.
Manhasset, New York

WABASH COUNTY

Walker, James L.....LaFontaine
Balsbaugh, Geo.....N. Manchester
Brubaker, O. G.....N. Manchester
Bunker, L. Z.....N. Manchester
Cook, Chas. E.....N. Manchester
Seward, Geo. W.....N. Manchester
Venable, Geo. L.....N. Manchester
Kidd, James G.....Roann
Black, Edgar K.....Wabash
Dannacher, Wm. D.....Wabash
LaSalle, Robert M.....Wabash
Mills, John F.....Wabash
Naugle, Raymond A.....Wabash
Rhamy, Arthur P.....Wabash
Steffen, Arthur J.....Wabash
Steffen, Julius T.....Wabash
Stoops, Jean T.....Wabash
Wall, Joseph A.....Wabash
Whisler, Frederick M.....Wabash

WARREN COUNTY

(See Fountain-Warren)

WARRICK COUNTY

Faith, I. L. .....Boonville
Hoover, J. Guy.....Boonville
Hoover, Peter B.....Boonville
Samples, John T.....Boonville
Stover, Wendell C.....Boonville
Wilson, Paul E.....Boonville
Wilhelmus, Charles M...Newburgh
Springstun, Charles E....Tennyson
Zwickel, Ralph E.
246 Stoneway Lane,
Merion Station, Pa.

WASHINGTON COUNTY

Tower, Thomas K...Campbellsburg
Green, William L.....Pekin
Allen, Fred K.....Salem
Episcopo, A. R.....Salem
Gilliatt, James P.....Salem
Huckleberry, Irvin E.....Salem
Paynter, Lawrence W. (H)..Salem
Mull, Philip L. (H)
Box 1432, Louisville, Ky.

WAYNE-UNION COUNTIES

Clark, Marion E...Cambridge City
Hill, Paul G.....Cambridge City
Kenyon, Charles E.Cambridge City
Barton, Willoughby M..Centerville
Hutchison, Donald R.Fountain City
McKee, Charles E. (H).....Dublin
Zimmerman, Wm. H.....Dublin
Marsh, Chester A.....Hagerstown
Miller, William A.....Hagerstown
Shively, John L.....Hagerstown
Dubois, Franklin T. (H)...Liberty
Lewis, James F.....Liberty
McWilliams, William B....Liberty
Thompson, Will A.....Liberty

Richmond

Ake, Loren
410 First Nat. Bk. Bldg.
Allen, Hubert E.....21 S. Eighth
Allen, Robert T.....21 S. Eighth
Ballenger, William E.
309 Med. Arts Bldg.
Blossom, Paul W.....825 S. A St.
Bond, Charles S. (H) 112 N. Tenth
Buche, Fredk. P.....106 S. Seventh
Campbell, Perry A.
422 Med. Arts Bldg.
Coble, Frank H.....51 S. Eighth
Cox, Leon T.....36 S. Eighth
Daubenheyer, M. F. Rich. St. Hosp.
Denny, Edgar C....Rich. St. Hosp.
Dingle, P. E.. 403 Med. Arts Bldg.
Ebbinghouse, Tom.....98 W. Main
Ewbank, J. Nelson
Smith-Esteb Hosp.
Faulkner, Wm. H.....29 S. 12th
Griffis, V. C....208 Med. Arts Bldg.
Hadley, Harvey..1st Nat. Bk. Bldg.
Hagie, Franklin E.
302 Second Nat. Bk. Bldg.
Harmon, C. J. 407 Med. Arts Bldg.
Harmon, G. H. 407 Med. Arts Bldg.
Hays, George R.
401 Second Nat. Bk. Bldg.
Hill, H. D.....412 Med. Arts Bldg.
Hoffman, Curtis R.
405 First Nat. Bk. Bldg.
Hunt, G. J.....130 Med. Arts Bldg.
Johnson, George M.
201 First Fed. Bldg.
Johnson, P. S. 215 Med. Arts Bldg.
Kime, Charles E.....810 S. A St.
Krueger, Fredk. W. 45 S. Seventh
Laird, Leslie A.....Rich. St. Hosp.
Lee, G. W.....139 Med. Arts Bldg.
Ling, John F...306 Med. Arts Bldg.
Logan, James Z.
203 Second Nat. Bk. Bldg.
Mader, John H.....808 South A
Malcolm, R... 127 Med. Arts Bldg.
Meredith, Elwood J.
203 Med. Arts Bldg.
Ross, Harry P.
410 Second Nat. Bk. Bldg.
Ross, James S...302 Colonial Bldg.
Ross, Louis F.
308 Second Nat. Bk. Bldg.
Runge, Paul W.....1426 E. Main
Sage, Charles V.....48 S. Eleventh
Shields, Tom S.....4 7S. Eleventh
Snyder, M. C..130 Med. Arts Bldg.
Stamper, L. A..402 Med. Arts Bldg.
Stepleton, J. D...Reid Mem. Hosp.
Sweet, H. E...20 S. Twenty-second
Taylor, W .R...308 Med. Arts Bldg.
Vance, W. C...136 Med. Arts Bldg.
Wanninger, Horace
408 Second Nat. Bk. Bldg.
Warrick, Francis B...1426 E. Main

WAYNE-UNION COUNTIES

(Richmond—Continued)

Weinstein, E. B..204 Colonial Bldg.
Wertenberger, Morris D.
Reid Mem. Hosp.
Whallon, Arthur J.....29 S. Tenth
Williams, Paul D...Rich. St. Hosp.
Wisener, G. H..213 Med. Arts Bldg.
Yencer, Martin W. (H)..22 N. 14th

Heck, Rolfe A...College Corner, O.
Shepard, Fred F.
College Corner, Ohio
Hufnagel, Chas. A...17 Broune St.,
Brookline, Mass.
Poston, Clement L..3618 Adams St.,
Bellwood, Ill.

WELLS COUNTY

Bluffton

Annis, Homer B.....303 S. Main
Aucreman, Charles S...303 S. Main
Brickley, Harry D.....227 S. Main
Brickley, Richard A....227 S. Main
Buckner, Joy F.....Bluffton
Caylor, Harold D.....303 S. Main
Caylor, T. E.....303 S. Main
Cook, Robert G.....303 S. Main
DeRyke, Gilbert R.....303 S. Main
Dorrance, Thos. O.....303 S. Main
Eisaman, Jack L.....303 S. Main
Gitlin, Max M.....121½ E. Market
Gitlin, William A....121 E. Market
Hamilton, O. G.....227 S. Main
Johnston, Robert L.....303 S. Main
Lloyd, John T.....303 S. Main
Mead, Clarence H.....227 S. Main
Nickel, Allen.....303 S. Main
Shively, John A.....303 S. Main
Talbert, Pierre C.....303 S. Main
Tirman, Wallace S.....303 S. Main
Yoder, Richard P.....303 S. Main

Gingerick, C. M.....Liberty Center
Davidoff, Manuel A.....Ossian
Hardin, Wayne E.....Ossian
Collett, Hugh S.....609 S. 42nd St.,
Philadelphia, Pa.
Holtzman, Paul W...Toledo Hosp.,
Toledo, Ohio
Sherman, Robert M...Christ Hosp.,
Cincinnati, Ohio

WHITE COUNTY

Galbreth, Jesse P.....Burnettsville
Derhammer, George L...Brookston
Netherton, Clyde R.....Chalmers
Houser, Wayne W.....Monon
McClure, Stanley E.....Monon
Carney, John C.....Monticello
Gable, Homer B.....Monticello
Hibner, Nolan .....Monticello
Morris, Warren V.....Monticello
Mayfield, Clifford H.....Reynolds
Forbes, Violet M. Crabbe..Wolcott
Hull, James E.....Wolcott

WHITLEY COUNTY

Briggs, Jesse H.....Churubusco
Hershey, Ernest A.....Churubusco
Heritier, Claude J...Columbia City
Langohr, John.....Columbia City
Lehmberg, Otto F...Columbia City
Nolt, Ernest V.....Columbia City
Pence, Benjamin F..Columbia City
Thompson, Frank...Columbia City
Garber, Paul A.....South Whitley
Huffman, Verlin P...South Whitley

MEMBERS OF WOMAN'S AUXILIARY

BY COUNTIES

ADAMS COUNTY

Berne

Beaver, Mrs. N. E..365 N. Harrison
Habegger, Mrs. M. L.....505 Clark
Reusser, Mrs. Amos..256 Sprunger

Decatur

Burk, Mrs. J. M.....221 S. Third
Carroll, Mrs. J. C.....R. R. 4
Duke, Mrs. B. E.....145½ S. Second
Girod, Mrs. A. H...1004 W. Monroe
Kohne, Mrs. G. J.....304 W. Adams
Parrish, Mrs. Richard.238 S. Second
Rayl, Mrs. C. C.....334 S. First
Reppert, Mrs. R. L...Road No. 224
Smith, Mrs. W. E.....116 S. Third
Terveer, Mrs. John.415 W. Madison
Zwick, Mrs. H. F.....401 E. Rugg

Geneva

Lehman, Mrs. H. B.....R. R. 1
Schetgen, Mrs. J. V.....Box 236

ALLEN COUNTY

Bluffton

Brickley, Mrs. H. D....227 S. Main
Buckner, Mrs. J.....116 E. Walnut
Hamilton, Mrs. O. G..203 E. Central
Mead, Mrs. C. H.....211 W. Wash.
Morris, Mrs. G. B...116 W. Market

Fort Wayne

A

Adams, Mrs. J. R.....621 W. Berry
Aiken, Mrs. A. F.....1927 E. State
Aiken, Mrs. N. E.....1923 E. State
Aldrich, Mrs. Harry.2710 Broadway

B

Bailey, Mrs. Paul..1840 Pemberton
Baltes, Mrs. Joseph...4816 Beaver
Bash, Mrs. W. E.....4626 Stratford
Beams, Mrs. Ralph.3206 S. Anthony
Beierlein, Mrs. Karl...Butler Road
Berghoff, Mrs. Raymond
2009 Forest Park
Blosser, Mrs. H. V..1122 W. Wash.
Bolman, Mrs. Morton
1038 Maxine Dr.
Bolman, Mrs. R. M.....1110 Maple
Bowers, Mrs. G. T...2609 E. Drive
Bowers, Mrs. J. W....817 E. Wash.
Brosius, Mrs. Robt.....1530 Lake
Brown, Mrs. Frederic
906 Woodview
Bruggeman, Mrs. H. O.
1202 W. Wash.
Buckner, Mrs. Doster.....Bass Rd.
Bulson, Mrs. Eugene
4301 Pembroke Lane

C

Calvin, Dr. Jessie...312 W. Wayne
Cameron, Mrs. D. F.2724 N. Clinton
Carlo, Mrs. E. R...4633 Crestwood
Cartwright, Mrs. E. L..529 Packard
Catlett, Mrs. M. B....1143 Rudisill
Clark, Mrs. J. H.....3805 S. Hanna
Clark, Mrs. W. H..4002 S. Harrison
Cooney, Mrs. C. J...1168 Westover
Cowan, Mrs. J. C..Lincoln Hwy. E.
Craig, Mrs. Richard...4315 Beaver
Culp, Mrs. J. E.....1216 Illsley

D

Dancer, Mrs. C. R....905 Columbia
Dunstone, Mrs. H. C..4134 Indiana

E

Eberly, Mrs. K. C..1240 W. Rudisill
English, Mrs. C. H....2509 Webster
Estlick, Mrs. Richard..4223 Beaver

F

Ferguson, Mrs. A. N.
2015 Pemberton
Foy, Mrs. H. W....1816 Forest Pk.
Fichman, Mrs. A. M..323 W. Berry

G

Garton, Mrs. H. W.
Hamilton Rd., R. R. 6
Gerding, Mrs. Wm....2943 Central
Gessler, Mrs. Wm..3927 S. Harrison
Glock, Mrs. Maurice...1913 Forest
Glock, Mrs. W. R 921 Lexington Ct.
Graham, Mrs. G. H..3813 Hiawatha

H

Haffner, Mrs .Herman
3606 Mulberry Rd.
Hamilton, Mrs. Emory
2405 Florida Dr.
Harshman, Mrs. L. P.
2704 N. Clinton
Harvey, Mrs. H. C...2228 Crescent
Hasewinkle, Mrs. A. M.
1807 E. Rudisill
Hastings, Mrs. W. C..1725 Huffman
Hattendorf, Mrs. A. P.
4041 Old Mill Rd.

ALLEN COUNTY

(Fort Wayne—Continued)

Havens, Mrs. Russell
1845 Kensington
Hoffman, Mrs. S. P.
234 E. Maple Grove
Hoffman, Mrs. Arthur 4223 Indiana
Holsinger, Mrs. R. E. 4617 Indiana
Horton, Mrs. G. R.
122 Sherwood Ter.
Howe, Mrs. F. L. 3714 Reed

J-K

Jurgenson, Mrs. Walter
454 Arcadia Ct.
Kent, Mrs. Richard 1836 Crescent
Kidder, Mrs. O. T.
Irene Byron San.
Kruse, Mrs. E. H. 2500 Randall Rd.

L

Ladig, Mrs. D. S. 1014 Rivermet
Lehner, Mrs. John 1119 Maxine Dr.
Lenk, Mrs. George
E. State Ext., R. R. 9
Lohman, Mrs. Robert 2138 Owaissa
Lloyd, Mrs. Robert 3609 S. Anthony
Loudermilk, Mrs. J. L.
1723 Pemberton

M

McArdle, Mrs. E. G.
1133 W. Rudisill
McBride, Mrs. W. O.
610 Beechwood Circle
McCoy, Mrs. R. R. 4702 Crestwood
McDowell, Mrs. G .A.
2322 Forest Pk.
McEachern, Mrs. C. G.
3914 Wawonaissa
McKeeman, Mrs. Donald
1615 Ardmore
McNairy, Mrs. D. J. 4522 Beaver
Martineau, Mrs. P. C. 3138 Fairfield
Mendenhall, Mrs. E. N.
232 S. Cornell Circle
Mercer, Mrs. S. R.
3235 N. Wash. Rd.
Meyer, Mrs. T. O. 4438 Wilmette
Michaelis, Mrs. S. C.
4311 Marquette
Miller, Mrs. C. G. 457 W. Oakdale
Miller, Mrs. H. P. 417 W. Pontiac
Miller, Mrs. Mahlon 1115 Illsley
Miller, Mrs. O. J. 1102 Kensington
Miller, Mrs. R. H. 1322 W. Foster
Miller, Mrs. W. J. 310 E. Wash.
Moats, Mrs. Geo. 2107 Kensington
Moravec, Mrs. Arthur
4711 Old Mill Rd.
Mortensen, Mrs. Leland
1310 W. Foster Pkwy.
Mueller, Mrs. Lawrence
3423 S. Wash. Rd.
Murdock, Mrs. H. L.
1212 Kensington

N-O

Nahrwold, Mrs. E. W.
3314 Irvington
Nill, Mrs. John 1116 Charlotte
Oyer, Mrs. J. R. 2206 Wawonaissa

P

Parker, Mrs. C. B. 4520 Beaver
Perrin, Mrs. Kermit Maysville Rd.
Perry, Mrs. Fredk. 709 Kinnaird
Popp, Mrs. Milton 3148 Parnell
Prentiss, Mrs. Nelson
919 Parkview Dr.

R

Ranke, Mrs. Henry 3112 Beaver
Ray, Mrs. Herbert
325 E. Creighton
Rhamy, Mrs. B. W. 3452 Portage
Rice, Mrs. W. B. 1023 Kinnaird
Rissing, Mrs. Walter
3200 Irvington
Rockey, Mrs. N. A 2411 Florida Dr.
Rodriguez, Mrs. Juan
4720 Crestwood Dr.
Roser, Mrs. Arthur Leesburg Rd.
Rossiter, Mrs. D. L 724 W. Oakdale
Rothberg, Mrs. Maurice
4801 Tacoma
Rothchild, Mrs. Chas. J.
3015 N. Anthony

S

Salon, Mrs. Harry 2423 Fairfield
Salon, Mrs. Nathan 1024 Kinnaird
Savage, Mrs. Arthur 102 Fairhill
Schafer, Mr. D. J., Jr.
4010 Wawonaissa
Schlegel, Mrs. E. H.
2219 N. Anthony
Schmoll, Mrs. R. J. 2129 Owaissa
Schneider, Mrs. L. A.
4621 S. Park Dr.
Scoins, Mrs. W. H. Taylor Rr., R. 8
Scott, Mrs. H. V. 5224 Fairfield
Shinabery, Mrs. Lawerence
1850 Broadway
Singer, Mrs. Elmer 825 Oakdale
Somers, Mrs. Gerald
227 W. Fleming
Stauffer, Mrs. Richard
2116 Wawonaissa
Stellner, Mrs. Howard
4314 S. Calhoun
Stier, Mrs. Paul 3807 Fairfield

T-V

Tennant, Mrs. David 5021 Fairfield
Terrill, Mrs. Richard
4727 Old Mill Rd.
Thornton, Mrs. W. E.
601 W. Oakdale
VanBuskirk, Mrs. E. M.
920 Maxine Dr.

W

Wallace, Mrs. J. C.
4003 S. Harrison
Warfield, Mrs. C. H.
1809 Kensington
Welty, Mrs. S. G. 509 W. Oakdale
Weber, Mrs. J. R. 1215 Sheridan
Wilkins, Mrs. Robert
4839 Old Mill Rd.
Williams, Dr. Berniece
3526 N. Wash. Rd.
Wilson, Mrs. Leslie 2810 S. Wayne
Wright, Mrs. Wm. C.
1834 Pemberton
Wyatt, Mrs. J. L., Jr.
3401 N. Wash. Rd.

Z

Zehr, Mrs. Noah 301 W. Creighton
Zweig, Mrs. Elmer 3365 Garland
Johnston, Mrs. D. D.
2444 N. Meridian, Indianapolis
Dahling, Mrs. C. W.
1206 Powers St., New Haven
Emenhiser, Mrs. D. C.
1040 Lincoln Hwy., New Haven
Hoetzer, Mrs. E. M. Briar Hill, R. 2
Smith, Mrs. G. A.
Lincoln Hwy., New Haven
O'Rourke, Mrs. Carrol Roanoke
De Voe, Mrs. Kenneth Woodburn

BARTHOLOMEW COUNTY

Columbus

Adler, Mrs. D. L. Laurel Dd.
Beggs, Mrs. L. F. 2733 Riverside
Carpenter, Mrs. T. D. 2328 Gilmore
Davis, Mrs. M. R. 2228 Lafayette
Fisher, Mrs. W. S. 906 Franklin
Hart, Mrs. R. B. 1203 Sixteenth
Hawes, Mrs. M. E. N. Washington
Henry, Mrs. Alvin
Kincaid, Mrs. J. C. 4 Mile Hse. Rd.
Macy, Mrs. George 2603 Wash.
Marr, Mrs. Griffith 1513 17th
Norton, Mrs. H. J. 909 Pearl
Overshiner, Mrs. Lyman
1715 Franklin
Ritteman, Mrs. G. W. Caldwell Dd.
Ryan, Mrs. W. J. 2244 Pearl
Williams, Mrs. E. W. 1902 Franklin
Wissman, Mrs. Wm. L.
1930 Lafayette
Yoder, Mrs. D. D. 713 Lafayette
Zaring, Mrs. B. K. 2419 Riverside

Dudding, Mrs. Jos. E. Hope

BENTON COUNTY

Taylor, Mrs. W. H. Ambia
Atkinson, Mrs. C. W. Boswell
Flack, Mrs. Minnie Boswell
Leak, Mrs. Robt. Boswell
Carnes, Mrs. Wm. Earl Park
Turley, Mrs. Verne L. Fowler
Muller, Mrs. L. P.
5608 College, Indianapolis 2
Smith, Mrs. Chas. G. Otterbein
Parker, Mrs. E. E. Oxford
Scheurich, Mrs. Virgil Oxford

CARROLL COUNTY

Van Kirk, Mrs. John Burlington
Brown, Mrs. Thomas C. Delphi
Crampton, Mrs. C. C. Delphi
Gros, Mrs. Hubert Delphi
Maccart, Mrs. Ralph Delphi
Wagoner, Mrs. George Delphi
Adams, Mrs. Max R. Flora
Brookie, Mrs. Roger Flora
McLaughlin, Mrs. James Flora
Mullin, Mrs. H. Y. Rockfield

CASS COUNTY

Dutchess, Mrs. C. T. Galveston
Lybrook, Mrs. D. E. Galveston

Logansport

Adamski, Mrs. M. S. 614 17th
Bailey, Mrs. E. W. 2522 North
Ballard, Mrs. C. A. R. R. 4
Bradfield, Mrs. John R. R. 4
Cooper, Mrs. T. L. 2104 North

CASS COUNTY

(Logansport—Continued)

Davis, Mrs. John.....2119 North
Fitzgerald, Mrs. Brice...1930 High
Hall, Mrs. B. R...1707 E. Broadway
Hedde, Mrs. E. L.....R. R. 5
Hickman, Mrs. W. R.....824 High
Hillis, Mrs. L. J..2508 E. Broadway
Holloway, Mrs. W. A.
200 Eel River
Holmes, Mrs. W. W.....R. R. 4
Jewell, Mrs. E. B.....3019 S. Penn.
Jones, Mrs. J. C.....1700 Michigan
Keefe, Mrs. Thos..900 E. Broadway
Maxwell, Mrs. J. B.....1119 High
Morrical, Mrs. Russell
920 Michigan
Schenck, Mrs. Foss
Longcliff St. Hosp.
Shultz, Mrs. Harry....412½ Fourth
Stewart, Mrs. M. B.....1308 High
Terflinger, Mrs. F. W.
2607 E. Broadway
Viney, Mrs. C. L.....R. R. 4
Wilson, Mrs. Paul.....207 18th
Winter, Mrs. D. K.....89 Ninth

Newcomb, Mrs. W. K..Royal Center
Flanagan, Mrs. E. P.....Walton

CLARK COUNTY

Goodman, Mrs. Eli
802 Market St., Charlestown
Willner, Mrs. Alan
117 N. Randolph, Clarksville

Jeffersonville

Adair, Mrs. S. L.....Utica Pike
Bizer, Mrs. Mier..218 Kewanna Dr.
Buckley, Mrs. E. P.....14 Blanchel
Burman, Mrs. R. G.....Utica Pike
Carlberg, Mrs. D. L.....2 Blanchel
Carney, Mrs. J. T.....203 Sparks
Dare, Mrs. L. A.....215 Sparks
Forsee, Mrs. N. E.....516 E. Court
Graham, Mrs. O. P....713 E. Maple
Huoni, Mrs. J. S....6 Blanchel Ter.
Isler, Mrs. Nathaniel
915 Morningside Dr.
Weems, Mrs. M. P...Hopkins Lane

Sellersburg

Regan, Mrs. George
Sturgis, Mrs. Donald G.
Vandevert, Mrs. Arthur

CLAY COUNTY

Brazil

Maurer, Mrs. J. F.....6 E. Park
Maurer, Mrs. R. M.
1115 N. Meridian
Palm, Mrs. J. M.....27 E. Church
Sourwine, Mrs. C. C..141 N. Walnut
Weaver, Mrs. T. M.....R. R. 2
Webster, Mrs. R. K.....25 Beech
Wood, Mrs. Opal L...428 E. Blaine

Clay City

Bond, Mrs. W. C.....8th & White
Glosson, Mrs. J. R.....316 N. Main

DAVIESS-MARTIN COUNTIES

Rohrer, Mrs. James.....Elnora
Chattin, Mrs. Robt.....Loogootee
Lett, Mrs. E. B.....Loogootee
Coleman, Mrs. H. G.....Odon
Sears, Mrs. Don.....Odon
Maschmeyer, Mrs. Robt.....Shoals

Washington

Blazey, Mrs. A.....E. Walnut
Burress, Mrs. B.....Pine Court
Chattin, Mrs. Vance....Greenacres
Farris, Mrs. J. J.....411 William
Fox, Mrs. Philip.....Greenacres
Lindsay, Mrs. H. B.....14 SE Fifth
McKittrick, Mrs. Jack..Greenacres
McKittrick, W. A.....Greenacres
McNaughton, Mrs. L. M.
812 E. Main
Norton, Mrs. Horace...511 Hefron
Rang, Mrs. Arthur....211 E. Ninth
Rang, Mrs. Robert....214 E. Ninth
Schafer, Mrs. Wm. C..211 E. Ninth
Schroeder, Mrs. Roland..Plainville
Shield, Mrs. Harry
1210 Bedford Rd.

DEARBORN-OHIO COUNTIES

Aurora

Baker, Mrs. L. M.....204 Fifth
Olcott, Mrs. C. W....305 Sunnyside
Stewart, Mrs. O. H.
2nd & Bridgeway
Treon, Mrs. J. F.....505 Fifth

McNeeley, Mrs. M. J.....Dillsboro
Elliott, Mrs. J. C.....Guilford

Lawrenceburg

Fagaly, Mrs. W. J.....55 Oakey
Pfeifer, Mrs. J. M.....550 Ludlow
Streck, Mrs. F. A.....Ridge Ave.
Vail, Mrs. G. A.....34 Oakey

Fessler, Mrs. Gordon...Rising Sun
Manley, Mrs. C. N.....Rising Sun

DELAWARE-BLACKFORD COUNTIES

Brown, Mrs. Stewart.....Albany
Hurley, Mrs. John.....Daleville
Tucker, Mrs. O. A.....Daleville
Lingeman, Mrs. Roger.....Eaton
Downard, Mrs. Leland.....Gaston
Langsdon, Mrs. Fred.....Gaston
Montgomery, Mrs. Lall ...Gaston
Douglas, Mrs. Paul.....Montpelier

Muncie

A

Adams, Mrs. Wm. B.
W. Jackson St. Pike
Alvey, Mrs. C. R.....3001 Torquay
Anthony, Mrs. H. M.
822 W. Charles

B

Ball, Mrs. C. A.....1015 Linden
Ballard, Mrs. J. E.....2303 S. Vine
Bibler, Mrs. H. E.....Parkway Dr.
Botkin, Mrs. C. G...2904 Riverside
Botkin, Mrs. Tom.....627 N. Elm
Bowles, Mrs. Herman..324 N. Vine
Bowles, Mrs. J. H.....408 Wayne
Brown, Mrs. K. T....905 E. Adams
Brown, Mrs. Leland....2012 W. 9th
Brown, Mrs. Tom....2117 W. 10th
Butterfield, Mrs. Robert
1002 W. Gilbert

C

Clauser, Mrs. E. H.....1 Briar Rd.
Clevenger, Mrs. J. H.
3124 University
Cole, Mrs. R. E.....431 W. Howard
Covalt, Mrs. W. E.....N. Tillotson
Cure, Mrs. E. T.....913 University

D

Davis, Mrs. E. C.....45 Warwick
Deutsch, Mrs. Wm.....2100 Petty
Downing, Mrs. F. J.
218½ W. Jackson
Dunn, Mrs. F. W....1416 Wheeling

E

Egbert, Mrs. Clarence.2010 S. Vine
Eissman, Mrs. Eugene
2724 W. Gilbert

F

Fitch, Mrs. John..1708 W. Jackson
Funk, Mrs. John....3834 Riverside

G

Garling, Mrs. L. C.....37 Briar Rd.
Gilbert, Mrs. N. G. Granville Pike
Greiber, Mrs. Marvin...3001 Devon
Gustafson, Mrs. Milton...920 Riley

H

Hall, Mrs. Orval...3121 W. Gilbert
Hayes, Mrs. T. R.....920 W. North
Henderson, Mrs. Ramon
300 Shady Lane
High, Mrs. Ralph..2825 University
Hill, Mrs. Frank....321 N. Calvert
Hill, Mrs. Howard .402 W. Jackson
Hill, Mrs. Robert State Rd. 3 South
Hostetter, Mrs. I. S..3010 Riverside
Hurley, Mrs. Anson
1007 University

I

Imhof, Mrs. Jos. Graystone Apts.

K

Kammer, Mrs. Walter 919 W. Main
Kemper, Mrs. Arthur 600 E. Wash.
Kirshman, Mrs. Forrest
41 Briar Rd.
Kuder, Mrs. Howard
1208 N. Walnut

M

Manifold, Mrs. Harold 2200 S. Vine
Mason, Mrs. Lester...3013 Oaklyn
Miller, Mrs. Charles..St. Rd. 67 N.
Molloy, Mrs. W. J...619 E. Charles
Morris, Mrs. J. W....609 McKenzie
Moss, Mrs. M. J.....2526 W. Main
McClellan, Mrs. John
613 W. Charles
McClintock, Mrs. James
316 W. Adams
McCoy, Mrs. George 222 E. Adams

DELAWARE-BLACKFORD COUNTIES

(Muncie—Continued)

O-P-Q

Owens, Mrs. O. W....2600 Godman
Owens, Mrs. Richd....2613 Godman
Owens, Mrs. Thos...608 E. Charles
Poland, Mrs. U. G.....303 E. Wash.
Quick, Mrs. Wm...2009 University

R

Rea, Mrs. C. G.....412 University
Rettig, Mrs. Arthur.611 W. Howard
Rivers, Mrs. Glynn.1333 N. Walnut

S

Schulhoff, Mrs. M. G.
1408 Wheeling
Silvers, Mrs. J. C.
3700 Peach Tree Lane
Silvers, Mrs. J. M...220 W. Adams
Stanley, Mrs. J. R....3120 Godman
Stocking, Mrs. Bruce.3014 Amhurst

T-V

Tindal, Mrs. Edw...423 W. Jackson
Tomlin, Mrs. H. M....921 W. Main
Trent, Mrs. I. N.....415 E .Adams
Venis, Mrs. Kemper.....502 Wade

W

Wadsworth, Mrs. W. W.
306 E. Jackson
Williams, Mrs. J. H..905 W. North
Wright, Mrs. C. H...Granville Pike

Y

Young, Mrs. Gerald....114 Berwyn

Hinchman, Mrs. Jean.....Parker
Moore, Mrs. Will.....Yorktown

DUBOIS COUNTY

Backer, Mrs. H. G.....Ferdinand

Huntingburg

Boswell, Mrs. Samuel
Bretz, Mrs. John...222 Van Buren
Bretz, Mrs. W. D.....214 Fourth
Davidson, Mrs. Thomas
Lukemeyer, Mrs. L. C.....216 Main
McKinney, Mrs. S. L....517 Fourth
Steinkamp, Mrs. E. F...302 Walnut
Stork, Mrs. H. K.....523 First
Williams, Mrs. F. P.....511 Geiger

Jasper

Casper, Mrs. John.....R. F. D. 5
Casper, Mrs. Jos...Terrace Heights
Heck, Mrs. M. C.....388 W. 15th
Held, Mrs. G. A...Terrace Heights
Klamer, Mrs. C. H....424 W. Sixth
Wagoner, Mrs. J. M..Terrace Hgts.

ELKHART COUNTY

Bristol

Neidballa, Mrs. E. G.....R. F. D. 1
Patrick, Mrs. G. B.....R. F. D. 1
Schlosser, Mrs. H. C..Seven Gables

Elkhart

Bender, Mrs. R. L...309 East Blvd.
Bloom, Mrs. G. R.....130 Glendale
Bolin, Mrs. R. S..1853 E. Beardsley
Bowdoin, Mrs. G. E.
1029 W. Lexington
Compton, Mrs. W. A.
2225 Greenleaf
Cormican, Mrs. Herbert L.
1621 E. Jackson
Crandall, Mrs. L. A.
Crandall's Pond, R. F. D. 3
De Dario, Mrs. L. M.1418 Greenleaf
Elliott, Mrs. L. A.....2001 Stevens
Fleming, Mrs. C. F..229 W. Jackson
Fleming, Mrs. J. M.
2220 E. Jackson
Horswell, Mrs. R. G.
1629 E. Jackson
Hull, Mrs. A. W.....905 Strong
Hunn, Mrs. M. E..202 W. Beardsley
Kintner, Mrs. B. E..3520 E. Jackson
Kistner, Mrs. A. W.
102 W. Beardsley
Koehler, Mrs. E. G.
807 N. Shore Dr., Simonton Lake
Lundt, Mrs. M. O.....519 S. Second
Markel, Mrs. I. J...215 W. Franklin
Mendez, Mrs. Carlos..325 Superior
Miller, Mrs. H. A., Jr.
309 E. Crawford
Miller, Mrs. S. T.....1230 Prairie
Mininger, Mrs. E. P.
413 W. Franklin
Mishkin, Mrs. Irving
217 N. Riverside Dr.
Paff, Mrs. W. A...E. Jackson Blvd.
Paine, Mrs. G. D.....419 Modrell
Possolt, Mrs. Thos..2806 E. Jackson
Sears, Mrs. M. M.
R. F. D. 3 West Indiana
Spray, Mrs. Page....658 Kilbourne
Stauffer, Mrs. W. A.....701 Strong
Stout, Mrs. R. B....1501 Greenleaf
Stubbins, Mrs. Wm...4101 S. Main
Swihart, Mrs. H. R..417 N. Second
Swihart, Mrs. L. F.2120 Broadmoor
Todd, Mrs. D. D....2001 E. Jackson
Wilson, Mrs. O. E.....922 Gordon
Work, Mrs. Jas. A., Jr.
4 St. Joseph Manor

Goshen

Amstutz, Mrs. H. C...2001 S. Main
Bender, Mrs. C. K.....624 S. Fifth
Freeman, Mrs. F. M...309 E. Wash.
Hostetler, Mrs. C. M....1602 S. 8th
Kelly, Mrs. W. R....310 E. Monroe
Kinzie, Mrs. D. K.....406 Sunset
Martin, Mrs. F. S.....R. F. D. 5
Miller, Mrs. M. E.Bx. 485, R.F.D. 5
Nelson, Mrs. D. C...1210 S. Eighth
Simmons, Mrs. L. H...606 S. Third
Vander Bogart, Mrs. H. E.
1411 S. Eighth
Westfall, Mrs. G. S..214 E. Lincoln
Yoder, Mrs. A. C.....816 S. Sixth

Norris, Mrs. E. B.....Middlebury
Chandler, Mrs. L. H...Millersburg

Nappanee

Fleetwood, Mrs. R. A.
151 E. Van Buren
Kendall, Mrs. F. M..801 E. Market
Price, Mrs. D. W...458 N. Madison
Price, Mrs. M. D...451 N. Hartman
Slabaugh, Mrs. Lotus..402 N. Main
Slabaugh, Mrs. J. S.

De Fries, Mrs. John....New Paris
Fosbrink, Mrs. E. L.....Syracuse
Hannah, Mrs. Jack W....Wakarusa
Elliott, Mrs. T. A. 4577 Utopia Dr.,
New Orleans 20, La.

FLOYD COUNTY

Sloan, Mrs. H. P....Lincoln Hgts.,
Clarksville
Gentile, Mrs. John P...Floyd Knobs
Engleman, Mrs. H. K..Georgetown
New Albany
Baker, Mrs. A. M...2523 Glenwood
Baxter, Mrs. Jas. W., Jr.
426 Woodrow
Baxter, Mrs. Jas. W., Sr.
1203 E. Spring
Baxter, Mrs. S. M.....Centralia
Bird, Mrs. J. E.....1308 E. Spring
Briscoe, Mrs. C. E..4113 E. Spring
Brown, Mrs. K. H.....1654 Hedden
Byrn, Mrs. H. W.....330 Beharrell
Cannon, Mrs. D. H.
Old Vincennes Rd.
Cohn, Mrs. Philip
Old Vincennes Rd.
Davis, Mrs. P. M.....Paoli Pike
Day, Mrs. G. H.....Haufeldt Lane
Edwards, Mrs. W.F...615 Beharrell
Garner, Mrs. W. H...922 E. Spring
Hall, Mrs. W. A.....1509 Shelby
Hauss, Mrs. A. P.....Silver Hills
LaFollette, Mrs. R. E.
2510 Glenwood Pk.
Leuthart, Mrs. C. P..1410 E. Spring
McCullough, Mrs. J. Y...Centralia
Pace, Mrs. Jerome.....Silvercrest
Paris, Mrs. J. M....2003 Lindbergh
Pierson, Mrs. P. R.....1430 Silver
Robertson, Mrs. A. N. 323 E. Ninth
Rogers, Mrs. S .T...1017 E. Spring
Schoen, Mrs. P. H.....1825 State
Streepey, Mrs. J. I..1102 E. Spring
Tyler, Mrs. F. T.....Daisy Lane
Voyles, Mrs. H. E....425 Beharrell
Weaver, Mrs. W. W..1104 E. Spring
Winstandley, Mrs. W. C.
815 Vincennes
Wolfe, Mrs. M. F...2303 E. Spring
Wolfe, Mrs. N. A.....1615 Indiana

FULTON COUNTY

Stinson, Mrs. A. E.....Athens
Miller, Mrs. Virgil.....Akron
Dielman, Mrs. F. C.....Fulton
Kelsey, Mrs. Lawrence...Kewanna
Kraning, Mrs. K. K.....Kewanna
Herendeen, Mrs. E. V....Rochester
Glackman, Mrs. John....Rochester
King, Mrs. Milo O.....Rochester
Richardson, Mrs. C. L....Rochester
Rowe, Mrs. Howard.....Rochester
Stinson, Mrs. Dean K....Rochester

GIBSON COUNTY

Arthur, Mrs. M. L.....Patoka
Geick, Mrs. R. G.....Ft. Branch
Klein, Mrs. H. P.
206 S. Main, Ft. Branch
Arthur, Mrs. H. M.....Hazelton
Oakland City
Clark, Mrs. C. M..511 W. Columbia
Turner, Mrs. M. A.
322 W. Columbia
Wood, Mrs. R. W.....628 W. Oak

Montgomery, Mrs. J. R..Owensville
Strickland, Mrs. K. S....Owensville

GIBSON COUNTY

(Continued)

Princeton

Alexander, Mrs. H. H..427 W. State
Carpentier, Mrs. H. F..319 E. State
Folck, Mrs. John K....530 N. Hart
Graves, Mrs. O. M....116 E. Spruce
McCarty, Mrs. V....403 W. Spruce
McElroy, Mrs. R. S....704 W. State
Maxam, Mrs. F. H.....426 N. Main
Peck, Mrs. James F..114 W. Water
Weitzel, Mrs. R. E..303 W. Walnut
Ziliak, Mrs. A. L.....625 S. Main

GRANT COUNTY

Malott, Mrs. Fred.....Converse
Koontz, Mrs. William.....Gas City

Marion

Abell, Mrs. Chas. F...Wabash Ave.
Ayres, Mrs. Wendell W..830 Jeffras
Bloom, Mrs. Ward A....Quarry Rd.
Braunlin, Mrs. R. E.....315 N. Hill
Brown, Mrs. C. R....624 S. Gallatin
Brown, Mrs. Robert M...825 Euclid
Daniels, Mrs. Earl O...106 North E
Daniels, Mrs. George...822 W. 4th
Eshleman, Mrs. L. H..2923 S. Wash.
Fisher, Mrs. Henry..1502 S. Wash.
Fisher, Mrs. P. J.....1714 E. 34th
Ginsberg, Mrs. S. T...32 Vet. Hosp.
Huff, Mrs. Asher.....704 Spencer
Hummel, Mrs. R. M...3751 S. Nebr.
McIlwain, Mrs. Robert (Dr.)
2170 S. Boots
Powell, Mrs. J. Paxton...River Dr.
Renbarger, Mrs. Lester
Wabash Park
Rohrer, Mrs. John G...711 Wabash
Simmons, Mrs. Fred H..520 Whites
Sullenger, Mrs. A. A..2821 S. Nebr.
Warren, Mrs. Carrol....803 W. 6th
Williams, Mrs. C. L..26 B Vet. Hos.
Young, Mrs. Robert....112 E. 14th

Taylor, Mrs. E. C.....Upland
Rifner, Mrs. Eugene S...VanBuren

HANCOCK COUNTY

Johnston, Mrs. W. R..Charlottsville
Scott, Mrs. Robert...Charlottsville
Ferrell, Mrs. J. E.....Fortville
Navin, Mrs. H. K.....Fortville

Greenfield

Allen, Mrs. Joseph ....17 E. South
Endicott, Mrs. W. H..28 N. Franklin
Gibbs, Mrs. Chas.....203 E. North
Gill, Mrs. D. D.....328 Park Ave.
Woods, Mrs. James....N. East St.

New Palestine

Larabee, Mrs. W. H.
Mace, Mrs. E. E.
Pierson, Mrs. Thomas

Kuhn, Mrs. Robert .....Wilkerson

HENDRICKS COUNTY

Foltz, Mrs. L. E.....Brownsburg
Scudder, Mrs. A. N....Brownsburg
Ellett, Mrs. John, Jr....Coatesville
Frantz, Mrs. M. E.....Danville
Gibbs, Mrs. J. W.....Danville
Huckleberry, Mrs. Carl D..Danville
Price, Mrs. Ernest H.....Danville
Terry, Mrs. Lloyd .....Danville
Ellis, Mrs. L. H.....Lizton
Wiseheart, Mrs. O. H..North Salem
Scamahorn, Mrs. M.....Pittsboro
Scamahorn, Mrs. O. T....Pittsboro
Stafford, Mrs. J. C.....Plainfield
Stafford, Mrs. W. C.....Plainfield

HENRY COUNTY

Scheetz, Mrs. Marion R..Lewisville
Hammer, Mrs. J. A.....Middleton
Marshall, Mrs. L. C....Mt. Summit
Blaize, Mrs. J. A.....New Castle
Bledsoe, Mrs. J. G.....New Castle
Fisher, Mrs. John.....New Castle
Foster, Mrs. Ray .....New Castle
Harrison, Mrs. B. L.....New Castle
Life, Mrs. Homer .....New Castle
McDonald, Mrs. F. C...New Castle
McElroy, Mrs. James..New Castle
Thorne, Mrs. Chas. E...New Castle

HOWARD COUNTY

Denton, Mrs. Larkin....Greentown
Shoup, Mrs. H. B.....Greentown

Kokomo

Boughman, Mrs. J. D.
1515 W. Jefferson
Bowers, Mrs. Copeland
1530 W. Taylor
Bowers, Mrs. Garvey
421 Morningside
Bowers, Mrs. John
1535 W. Jefferson
Bruegge, Mrs. T. J...1414 Kingston
Clarke, Mrs. Elton
1400 W. Superior
Conley, Mrs. Thomas
1016 W. Superior
Craig, Mrs. Rueben.113 Leafy Lane
Cuthbert, Mrs. F. S.1027 W. Walnut
Druley, Mrs. G. N.....402 Ruddell
Ferry, Mrs. Paul.1207 W. Sycamore
Good, Mrs. Richard....417 Conradt
Halfast, Mrs. Richard
310 W. Markland
Hutto, Mrs. Omer.1012 W. Walnut
Hutto, Mrs. W. H.....211 Conradt
Jewell, Mrs. Geo...1525 W. Walnut
Kratzer, Mrs. E. F..320 W. Walnut
Lung, Mrs. Bruce.... 115 Conradt
Meiner, Mrs. J. A....924 W. Wash.
Morrison, Mrs. D. A.
1719 W. Taylor
Morrison, Mrs. W. R...413 Conradt
Murray, Mrs. Ernest..1329 W. Jeff.
Paris, Mrs. Durward.S. LaFountain
Phares, Mrs. Robert
905 W. Mulberry
Rhorer, Mrs. H. M.
511 W. Sycamore
Schuler, Miss Lucy....502 N. Main
Schuler, Mrs. R. P.....502 N. Main
Schwartz, Mrs. Frederick
1502 Kingston Rd.
Shenk, Mrs. E. M...306 N. Webster
Sorensen, Mrs. Raymond
1526 W. Sycamore
Spangler, Mrs. Jesse
214 E. Mulberry

Evans, Mrs. Robert....Russiaville
Tranter, Mrs. Frank...Sharpsville

HUNTINGTON COUNTY

Omstead, Mrs. L. W.....Andrews

Huntington

Brubaker, Mrs. H. S....919 Poplar
Casey, Mrs. S. M....408 E. Market
Cope, Mrs. Stanton...1022 N. Jeff.
Erehart, Mrs. M. G....Maple Grove
Eviston, Mrs. J. B.....1939 Poplar
Galbreath, Mrs. R. S...16 W. Wash.
Gray, Mrs. Paul M...340 E. Market
Grayston, Mrs. Fred W..708 N. Jeff.
Grayston, Mrs. W. S..303 E. Market
James, Mrs. Thos.....242 George
Johnston, Mrs. R. G..339 E. Market
Marks, Mrs. H. H.....1433 Cherry
Meiser, Mrs. R. D.....1739 Cherry
Mitman, Mrs. F. B.....1470 Poplar
Nie, Mrs. G. M.....1518 Cherry
Ware, Mrs. J. R.....622 Henry

Woods, Mrs. H. C.....Markle
Bennett, Mrs. J. B.....Warren
Black, Mrs. Claude S.....Warren
Bonifield, Mrs. H. F.....Warren
Smith, Mrs. L. W.....Warren

JASPER-NEWTON COUNTIES

Pippenger, Mrs. Wayne .....Brook
Openshaw, Mrs. J. F.....Goodland
Smith, Mrs. M. Hunter..Goodland
Glick, Mrs. O. E.....Kentland
Roesch, Mrs. Ryland ....Kentland
Yegerlehner, Mrs. R. S...Kentland
Zieger, Mrs. Irwin.....Morocco
Beaver, Mrs. E. R.....Rensselaer
English, Mrs. Harry ...Rensselaer
Kresler, Mrs. L. E.....Rensselaer
Shummaker, Mrs. Eugene
Rensselaer
Schantz, Mrs. Richard..Remington
Sink, Mrs. Frank .....Remington

JAY COUNTY

Heller, Mrs. Norman C...Dunkirk

Portland

Badders, Mrs. A. C...709 W. North
Dulin, Mrs. Basil B....321 E. Race
Engle, Mrs. John Max
503 W. Walnut
Hammond, Mrs. Stanley Mead
Hennessee, Mrs. Philip C.
603 W. Arch
Keeling, Mrs. Forrest E.
609 W. Race
Moran, Mrs. Mark M.
403 E. Walnut
Morrison, Mrs. George G.
North & Park St.
Spahr, Mrs. Donald E..615 W. Race
Schwartz, Mrs. W. D...234 E. High

Hanna, Mrs. Duke.....Redkey

JEFFERSON COUNTY

Madison

Childs, Mrs. W. E.....Elm & Third
Jolly, Mrs. L. E.....J.P.G. Area
Kemp, Mrs. M. W...Mad. St. Hosp.
May, Mrs. G. A.....R.F.D. 5
Petway, Mrs. A. P.....411 W. First
Whitsitt, Mrs. S. A....718 W. Main
Zink, Mrs. R. O.....426 Vine

JOHNSON COUNTY

Edinburg

Baker, Mrs. J. V.....215 W. Main

Franklin

Deppe, Mrs. Chas. F.....1215 Park
Eaton, Mrs. L. D..651 W. Jefferson
Ferrara, Mrs. Jos...241 N. Forsyth
Jones, Mrs. Chas. A..589 N. Graham
Manuel, Mrs. D. C....89 N. Walnut
Murphy, Mrs. H. E....150 N. Main
Murphy, Mrs. Geo...422 N. Walnut
Payne, Mrs. Carl F....151 N. Main
Portteus, Mrs. W. L...1000 E. King
Province, Mrs. O. A...99 N. Water
Province, Mrs. W. D..186 Maple La.
Records, Mrs. Arthur W.
216 E. Jefferson
Wilson, Mrs. R. C.....351 E. King

Greenwood

Brown, Mrs. G. E....52 S. Madison
Cox, Mrs. Edith.....375 W. Wiley
Craig, Mrs. J. A.....E. Pearl St.
Machledt, Mrs. John
243 S. Madison
Sheek, Mrs. K. I.....165 N. Brewer
Tiley, Mrs. Geo. A...41 N. Madison
Woodcock, Mrs. Charles E.
240 S. Madison

KNOX COUNTY

Raper, Mrs. G. T.....Freelandville
Springston, Mrs. George..Oaktown

Vincennes

Anderson, Mrs. Richard M.
Arbogast, Mrs. Paul B.
Beckes, Mrs. Ellsworth W.
Coffel, Mrs. Melvin H.
Curtner, Mrs. M. L.
Edwards, Mrs. E. T., Jr.
Ewing, Mrs. Nathaniel D.
Fox, Mrs. Maurice S.
Green, Mrs. Carl L.
Humphreys, Mrs. Joe E.
McCormick, Mrs. H. D.
McDowell, Mrs. M. M.
McMahan, Mrs. V. C.
Nance, Mrs. W. K.
Reilly, Mrs. James F.
Schulze, Mrs. William
Smith, Mrs. Ralph O.
Smith, Mrs. J. Joseph
Spencer, Mrs. Frederic
Welch, Mrs. Norbert M.

Pierce, Mrs. Gene S.....Wheatland

KOSCIUSKO COUNTY

McIlroy, Mrs. R. J.....Claypool
Urschel, Mrs. Dan .....Mentone
Herring, Mrs. Geo. N.....Pierceton
Schuldt, Mrs. T. S.....Pierceton

Warsaw

Haymond, Mrs. G. M...216 N. Lake
Leininger, Mrs. H. A. P.
1226 E. Market
Murphy, Mrs. S. C.....216 S. High
Schlemmer, Mrs. G. H..528 N. Lake

LAKE COUNTY

Thegze, Mrs. George
123 W. Detroit, Calumet City
King, Mrs. R. W.....Cedar Lake
Troutwine, Mrs. W. R....Crown Pt.

East Chicago

Arnold, Mrs. M. F....4239 Magoun
Benchik, Mrs. Frank..4712 Magoun
Bonaventura, Mrs. Angelo P.
1604 142nd
Boys, Mrs. F. F.....4143 Northcote
Cotter, Mrs. E. R...4220 Homerlee
Cotter, Mrs. Thomas.....4221 Ivy
Ernst, Mrs. H. C.....4219 Baring
Fleischer, Mrs. J. C.....4135 Ivy
Grosso, Mrs. William G.
3205 Grand Blvd.
Gustaitis, Mrs. J. W.....3810 Ivy
Johns, Mrs. David R...1211 Beacon
Kaplan, Mrs. B. B.....4117 Ivy
McGuire, Mrs. D. F.....1910 142nd
O'Conner, Mrs. J. J.....3717 Ivy
Petronella, Mrs. S. J...4308 Baring
Shapiro, Mrs. Jos.....3919 Fern
Niblick, Mrs. Jas. S...4122 Parrish
Mather, Mrs. J. W.
2367 Vigo, East Gary

Gary

Almquist, Mrs. C. O....550 Lincoln
Behn, Mrs. C. A.....652 McKinley
Bills, Mrs. R. N.....534 Lincoln
Brady, Mrs. Sam'l..3619 VanBuren
Carbone, Mrs. Jos.....526 Johnson
Elliott, Mrs. Ralph....1726 W. 6th
Goldstone, Mrs. Adolph.1430 W. 7th
Goldstone, Mrs. Jos..600 Cleveland
Kahn, Mrs. Harry.....403 Johnson
Kopcha, Mrs. Joseph....715 Hayes
Korn, Mrs. Jerome.....3653 Polk
Lorenty, Mrs. T. B...3654 Madison
May, Mrs. M. R.....667 Van Buren
Minczewski, Mrs. R. C...351 Chase
Molengraft, Mrs. C. J...534 Monroe
Nelson, Mrs. W. A....1002 Warren
Ornelas, Mrs. J. P.....4124 Monroe
Palmer, Mrs. Russell...2006 W. 4th
Parratt, Mrs. L. W...3526 Madison
Rubin, Mrs. Milton...609 Rutledge
Sala, Mrs. J. J.....537 Taft Pl.
Schaible, Mrs. Ernst.620 Buchanan
Senese, Mrs. T. J.....581 Johnson
Shellhouse, Mrs. M.....3671 Adams
Spellman, Mrs. F. W....640 Illinois
Stimson, Mrs. H. R..4338 Jefferson
Vye, Mrs. Preston J..3620 Madison
Wharton, Mrs. R. C....703 Johnson
Young, Mrs. C. M.....4580 Wash.

Malmstone, Mrs. F. A.
114 E. Main, Griffith

Hammond

Allegretti, Mrs. Michael
37 Elizabeth
Beconovich, Mrs. Robt.....2 Ruth
Beilke, Mrs. C. A.....6806 Huron
Brown, Mrs. S. L.....6550 Hohman
Chidlaw, Mrs. B. W.
29 Wildwood Rd.
Clancy, Mrs. James...7258 Forrest
Cook, Mrs. G. M.....6607 Forrest
Eggers, Mrs. Ernst....437 Detroit
Eggers, Mrs. Henry..6542 Hohman
Elledge, Mrs. Ray....6415 Forrest
Ewing, Mrs. J. K.....55 Kenwood
Gevirtz, Mrs. M. B....6528 Forrest
Hack, Mrs. E. C.....7174 Olcott
Hopkins, Mrs. J. R.....265 Conkey
Husted, Mrs. Robert.224 Fernwood
Jones, Mrs. E. S.....50 Kenwood
Kenney, Mrs. F. D.....913 175th
Komoroske, Mrs. J. E..35 Highland
Koransky, Mrs. David.7306 Tapper
Kretsch, Mrs. R. W...7214 Hohman
Marks, Mrs. O. L.....7111 Olcott
Marks, Mrs. S. P.....539 Cherry
Mathews, Mrs. C. B...6416 Forrest
Nakadate, Mrs. K. J..7335 Calumet
Neal, Mrs. L. W.....2237 169th
Nelson, Mrs. R. B....6741 Hohman
Nichols, Mrs. W. E.....15 Warren
Panares, Mrs. S. V.....4 172nd Pl.
Peck, Mrs. Edward.....411 165th
Ramker, Mrs. D. T...6827 Kennedy
Remich, Mrs. A. C....6412 Moraine
Rendel, Mrs. T. E.....7612 Monroe
Rhind, Mrs. A. W.....7126 Forrest
Row, Mrs. P. Q.....6706 Hohman
Rudolph, Mrs. F. G...216 Lawndale
Schlesinger, Mrs. J....1251 Forrest
Shanklin, Mrs. E. M.....14 Ruth
Stern, Mrs. S. L.....226 Oakwood
Tilka, Mrs. Edward.....1037 River

Dupes, Mrs. L. E..727 Main, Hobart

Lowell

Combs, Mrs. L. W.
N. Cedar Creek Twp.
Davis, Mrs. Neal
Mirro, Mrs. J. A.

Munster

Arbeiter, Mrs. Herbert..229 Beldon
Arrowsmith, Mrs. James L.
8138 Forrest
Larrabee, Mrs. J...8143 State Line
Rosevear, Mrs. Henry..230 Beldon

Whiting

Dainko, Mrs. Alfred.....618 118th
Jones, Mrs. C. M....1925 Westpark
Potts, Mrs. William
3543 Ridgeway, Lansing, Ill.

LAPORTE COUNTY

LaPorte

Carter, Mrs. Fred...Jefferson Ave.
Cartwright, Mrs. J. D...202½ E St.
Elshout, Mrs. C.....1037½ Indiana
Fischer, Mrs. C. N....1001½ Maple
Jones, Mrs. John C..2102 Michigan
Jones, Mrs. R. B.....1515 Indiana
Kelsey, Mrs. Robt. M..2107 Monroe
Kepler, Mrs. R. W...1529 Michigan
Larrimore, Mrs. Ward.911½ Maple
Muhleman, Mrs. C. E...Greenacres
Przednowek, Mrs. A. C.
909 Madison
Richter, Mrs. John C..1421 Indiana
Shick, Mrs. Lois.....307 E St.
VonAsch, Mrs. Geo.....912 Monroe

Michigan City

Armstrong, Mrs. Thomas D.
E. Coolspring Ave.
Baker, Mrs. Warren
516 E. Coolspring Ave.
Bankhoff, Mrs. M. L....1412 Wash.
Bernoske, Mrs. Daniel G...731 Pine
Fargher, Mrs. F. M.
Pottawattomie Park
Flaherty, Mrs. W. T...Long Beach
Gardner, Mrs. M. D.....2512 Oak
Gardner, Mrs. R. A.....Long Beach
Gilmore, Mrs. R. A.....815 Wash.

LAPORTE COUNTY

(Michigan City—Continued)

Kemp, Mrs. John T.....631 Pine
Kling, Mrs. V.
2105 Oakenwald, Long Beach
Kohrman, Mrs. B. M...209 Holliday
Krieger, Mrs. George M.
701 Washington
Kubik, Mrs. F. J.....613 Gardena
Lava, Mrs. I. M....509 Lake Shore
Meyer, Mrs. Milo G....Long Beach
Piazza, Mrs. L. F.
404 Warren Building
Straus, Mrs. David.....131 E. 8th

Weinstock, Mrs. A..Rolling Prairie
Moosey, Mrs. Louis....Union Mills
Benz, Mrs. O. F.....Wanatah
Hetman, Mrs. Mitchell...Westville
Plank, Mrs. C. R.
2005 Nethercliff Way,
Long Beach, Mich.

MADISON COUNTY

Anderson

Aagesen, Mrs. W. J....Forest Hills
Armington, Mrs. J. C...206 E. 14th
Armington, Mrs. R. L..Kilbuck Rd.
Austin, Mrs. M. A.....238 W. 12th
Ayres, Mrs. K. D....2210 Meridian
Baughn, Mrs. W. L...1635 W. 12th
Benoit, Mrs. M.....1504 Crystal
Blassaras, Mrs. C. A..2018 Mounds
Brauchla, Mrs. C. H....2421 Nichol
Brock, Mrs. E. E.....Madison Hts.
Buckles, Mrs. D. L..... 233 W. 8th
Conrad, Mrs. E. M...2124 Meridian
Coy, Mrs. F. M.....1732 W. 11th
Dixon, Mrs. R. W.....934 W. 8th
Drake, Mrs. John C...Madison Hts.
Ellis, Mrs. Seth W.....335 W. 5th
Erehart, Mrs. A. D.....1221 Irving
Fischer, Mrs. Warren E.
Grandview Terrace
Gante, Mrs. H. W.....2005 Nichol
Guthrie, Mrs. F. C.....2205 Nichol
Hart, Mrs. Wm. D.....1026 W. 8th
Hensler, Mrs. B. M..Edgewood Add.
Jones, Mrs. A. T.....1930 W. 12th
Kelly, Mrs. Wendell C.
R. R. 8, Edgewood Add'n
King, Mrs. Bernard A.
1217 Victory Court
King, Mrs. Jos. W..Edgewood Add.
Lamey, Mrs. Paul T...1740 W. 10th
Larmore, Mrs. J. L..Edgewood Add.
Litzenberger, Mrs. Sam W.
Forest Hills
Long, Mrs. Paul L.....1916 W. 9th
McDonald, Mrs. Vergil C.
Country Club Estates
Metcalf, Mrs. Geo. B....830 W. 8th
Neale, Mrs. Alfred E...630 Madison
Nesbit, Mrs. L. L.....8th St. Rd.
Patterson, Mrs. W. K...2747 Nichol
Polhemus, Mrs. W. C..1800 W. 11th
Rosenbaum, Mrs. L. E. Forest Hills
Ross, Mrs. Guy E....1209 Delaware
Rozelle, Mrs. C. V.....Forest Hills
Sharp, Mrs. William L.
Country Club Estates
Stamper, Mrs. Joseph
R. R. 7, Box 47
Swan, Mrs. R. C.....Forest Hills
Wilder, Mrs. G. B.....338 W. 8th
Williams, Mrs. R. H...1907 W. 10th
Wilkinson, Mrs. Roger L.
Edgewood Addition
Wishard, Mrs. F. B.....905 W. 9th
Zierer, Mrs. R. O...Woodlawn Hts.

Drake, Mrs. Marion C.....Elwood
Laudeman, Mrs. W. A.....Elwood
Scea, Mrs. Wallace A.....Elwood
Bishop, Mrs. Harry A....Frankton
Elsten, Mrs. Wayne A.....Lapel
Bridges, Mrs. W. L.....Markleville
Metcalf, Mrs. George B..Pendleton
Williams, Mrs. F. M.....Pendleton

MARION COUNTY

Ramage, Mrs. Walter F.
244 S. 1st, Beech Grove
Himebaugh, Mrs. James R. S.
R. R. 2, Box 46A, Greenwood

Indianapolis

A

Adkins, Mrs. Harold C.
250 W. Hampton Dr.
Adkins, Mrs. O. C. 3635 Watson Rd.
Albertson, Mrs. Frank P.
5031 Rockville Rd.
Aldrich, Mrs. H. D.....3039 Park
Alvis, Mrs. E. O...R. R. 14, Box 203
Arbogast, Mrs. J. L.
3516 Carrollton
Arbuckle, Mrs. Russell L.
3716 Watson Rd.
Arbuckle, Mrs. Wm. E.
1759 W. Morris

B

Bachmann, Mrs. A. J..3239 Winfield
Bakemeier, Mrs. Otto H.
5535 E. St. Clair
Ball, Mrs. Jos. E.....823 N. Lesley
Bartley, Mrs. Max D....107 E. 48th
Batman, Mrs. Gordon W.
6110 N. Delaware
Beasley, Mrs. Thomas J.
112 Berkeley Rd.
Beaver, Mrs. H. W...602 N. Beville
Bibler, Mrs. L. D.....3821 Guilford
Bird, Mrs. Charles
3758 N. Penn., No. 3
Bloemker, Mrs. E. F..935 Cameron
Boggs, Mrs. E. F.....1422 Loretta
Bowman, Mrs. George W.
215 Berkeley Rd.
Boyer, Mrs. E. S.....6024 E. 10th
Boyer, Mrs. F. A...136 S. Wittfield
Brady, Mrs. T. A..440 Berkeley Rd.
Brayton, Mrs. John R.
3128 E. Fall Ck. Blvd., N. Dr.
Brodie, Mrs. Donald W.
R. R. 12, Box 24M
Brown, Mrs. Edw. A...5420 Central
Brown, Mrs. W. E.....3750 N. Gale
Browning, Mrs. James S.
5880 N. Delaware
Browning, Mrs. W. M..5039 W. 13th
Brubaker, Mrs. E. H....624 E. 23rd
Burdette, Mrs. Harold F.
1503 N. Penn., No. 701
Burney, Mrs. L. E...321 Blue Ridge

C

Cahal, Mrs. Ernest E....27 E. 39th
Cahn, Mrs. Hugo M.....3038 Park
Call, Mrs. Herbert F....710 E. 57th
Campbell, Mrs. John A.
5201 Grandview Dr
Carter, Mrs. Oren E..5461 Kenwood
Clark, Mrs. Lawson J.
2425 E. Kessler Blvd.
Coble, Mrs. R. R.....5530 Central
Conley, Mrs. Jos. L....1617 E. Ohio
Conway, Mrs. Glenn
2235 E. Garfield Dr.
Cornacchione, Mrs. M.
5703 Broadway Terrace
Cortese, Mrs. J. V..1421 N. Tuxedo
Cortese, Mrs. Thomas A.
3240 Brill Rd.
Cox, Mrs. C. E. R. R. 16, Box 593
Culbertson, Mrs. C. G....6060 Park
Cuthbert, Mrs. Marvin
5611 N. Delaware

D

Davidson, Mrs. N. Cort
3135 N. Delaware
Davis, Mrs. Sam J.....5114 Park
Day, Mrs. Clark.....29 W. 42nd
Dearmin, Mrs. Robert M.
5147 N. Delaware
DeArmond, Mrs. Murray
5401 N. Delaware
Deever, Mrs. John W. 4160 Madison
Denny, Mrs. James W.
84 N. Audubon Rd.
Dilts, Mrs. Robt. L....5700 E. 38th
Donato, Mrs. A. N.....4225 S. East
Dorman, Mrs. W. Leland
R. R. 9, Box 157
Dugan, Mrs. William M.
5747 Rolling Ridge Rd.
Dunbar, Mrs. Colin V.
3615 Watson Rd.
Dyar, Mrs. E. W..5910 Wash. Blvd.

E

Eastman, Mrs. Jos. Rilus
8160 N. Meridian
Eaton, Mrs. Edwin R....3037 Park
Ebert, Mrs. J. Wayne
1601 Homecroft Dr.
Eberwein, Mrs. John H.
414 E. Fall Creek Pkwy., N. Dr.
Egbert, Mrs. Herbert L.
3210 Washington Blvd.
Eicher, Mrs. Palmer.....4902 Park
Eldridge, Mrs. G. E....3839 Central
Ellis, Mrs. Bert E..... 547 E. 36th
Emhardt, Mrs. J. T....2957 S. East
Emhardt, Mrs. John William
5424 Washington Blvd.
Ernst, Mrs. C. E....3206 N. Sharon
Evans, Mrs. Paul V..5725 Indianola
Everly, Mrs. Ralph....1105 E. 58th

F

Fausset, Mrs. Basil 5236 Graceland
Flick, Mrs. John.. 3021 N. Sharon
Flora, Mrs. J. O. 5604 Rockville Rd.
Folkening, Mrs. N. O.
1301 Woodlawn Ave.
Foreman, Mrs. Harry L.
3835 Washington Blvd.
Fosler, Mrs. David W.
5718 N. Delaware
Fouts, Mrs. Paul J..8391 N. Illinois
Fromhold, Mrs. W. A..5514 Manker
Fry, Mrs. Robt. D. 5717 Broadway

G

Gabe, Mrs. William E.
502 W. Hampton Dr.

MARION COUNTY

(Indianapolis—Continued)

Gambill, Mrs. William D.
R. R. 17, Box 66
Gammieri, Mrs. Pasquale
4453 Guilford Ave.
Garber, Mrs. J. Neill
4535 Marcy Lane
Garceau, Mrs. Geo. J..4334 N. Penn.
Gardiner, Mrs. Sprague H.
46 W. 52nd St.
Gardner, Mrs. Buckman
315 W. Hampton Dr.
Garrett, Mrs. John D.
2523 Central, No. 2
Garrett, Mrs. Robert A.
5022 Winthrop Ave.
Gastineau, Mrs. Frank M.
5344 N. Penn. St.
Geider, Mrs. Roy A.
5816 Pleasant Run Pkwy.
George, Mrs. Charles..1121 E. 80th
Gifford, Mrs. Fred E.
5125 N. Meridian
Gillespie, Mrs. C. F....2615 E. 35th
Gillespie, Mrs. J. E....4426 Bdway.
Goldman, Mrs. Sam..5632 Rosslyn
Gosman, Mrs. Jas. H..340 E. Maple
Gramling, Mrs. Joseph J.
4209 N. Capitol Ave.
Graves, Mrs. John W.
949 Ellenberger Pkwy., E. Dr.
Greist, John H.....5032 Park Ave.
Grisell, Mrs. Ted L..3237 Winthrop
Gustafson, Mrs. Gerald W.
5768 N. Penn.

H

Habich, Mrs. Carl...4335 Broadway
Hadley, Mrs. David
3132 N. New Jersey
Haggard, Mrs. E. B.
3481 Birchwood Ave.
Hahn, Mrs. E. V....R.R. 2, Box 529
Hall, Mrs. Frank.....6909 College
Hall, Mrs. Jack R....3542 Kenwood
Hampshire, Mrs. Donald
4378 Central
Hamer, Mrs. Homer.8454 N. Penn.
Hansell, Mrs. Robert M.
3523 N. Gladstone
Harcourt, Mrs. A. K....4915 N. Ill.
Harding, Mrs. M. R...2830 W. 33rd
Harold, Mrs. Albert H.
7510 Allisonville Rd.
Haslinger, Mrs. C. J.
5236 Boulevard Pl.
Haymond, Mrs. Jos. L..551 E. 36th
Hays, Mrs. E. L.....2607 Manker
Hedrick, Mrs. Philip...652 E. 54th
Helmer, Mrs. O. M..5015 N. Illinois
Hendricks, Mrs. J. W...124 W. 64th
Hetherington, Mrs. A. M.
5224 Pleasant Run Blvd., N. Dr.
Heubi, Mrs. J. E....5061 N. Illinois
Hickman, Mrs. W. F..5125 N. Penn.
Hippensteel, Mrs. Russell
3540 N. Meridian
Hoag, Mrs. W. I....2627 W. Wash.
Holman, Mrs. Jerome E., Jr.
5359 Guilford
Holman, Mrs. James E., Sr.
R. R. 13, Box 73
Hood, Mrs. A. A.....1444 W. 25th
Howell, Mrs. R. D.....930 E. 56th
Hudson, Mrs. Foster J.
525 W. Hampton Dr.
Hughes, Mrs. J. E..1628 Carrollton
Hughes, Mrs. W. F., Sr.
4025 N. Meridian

I-J

Iske, Mrs. Paul G.3601 N. Meridian
Jaeger, Mrs. Alfred S.
2935 Washington Blvd.
Jay, Mrs. Arthur N.
4319 Kingsley Dr.
Jenkins, Mrs. R. E.....124 W. 37th
Jennings, Mrs. Frank
Sunnyside Sanatorium
Jewett, Mrs. J. H.....4907 Rosslyn
Jinks, Mrs. C. H....5740 Carrollton
Johnson, Mrs. Thomas W.
5737 Washington Blvd.
Jones, Mrs. D. E...646 Berkley Rd.
Joseph, Mrs. Rex M....624 Lincoln

K

Katterjohn, Mrs. Jas...102 E. 50th
Keenan, Mrs. Reid L.
3702 N. Delaware
Keiser, Mrs. V. D...5709 Broadway
Kelly, Mrs. John F..5464 N. Capitol
Kelly, Mrs. Walter F.
6845 E. Pleasant Run Pkwy.
Kempf, Mrs. Gerald F.
2605 E. Riverside
Kennedy, Mrs. Hunter
757 N. Bolton
Kerr, Mrs. Harry R.
5774 Washington Blvd.
Kime, Mrs. Edwin N.
239 Buckingham Dr.
Kingsbury, Mrs. John K.
5776 E. Michigan
Kirklin, Mrs. O. L.
8005 Englewood Rd.
Kiser, Mrs. Edgar F...5610 Central
Kitterman, Mrs. Harry E.
5108 Graceland
Knowles, Mrs. C. Y.
1121 N. Downey
Kohlstaedt, Mrs. K. G...645 E. 80th
Koons, Mrs. Karl....5767 N. Penn.
Kopp, Mrs. H. S...3710 N. Colorado
Kornafel, Mrs. L. H...6201 College
Kraft, Mrs. Bennett
7025 Washington Blvd.
Kuntz, Mrs. H. W....823 Weghorst
Kurtz, Mrs. Philip L...6841 Willow

L

LaDine, Mrs. C. B.....4221 E. 35th
Lamb, Mrs. Emmett B.
1180 Golden Hill Dr.
Lamb, Mrs. R. W...4636 N. Capitol
Lamber, Mrs. Chet K.
1434 N. Delaware
Larkin, Mrs. Bernard J.
3103 N. Meridian
Lawler, Mrs. George F.
5601 E. St. Clair
Leasure, Mrs. J. Kent
5831 Washington Blvd.
Leonard, Mrs. H. S....4123 E. 30th
Lewis, Mrs. R. J....3742 N. Denny
Lichtenberg, Mrs. Melvin
4021 N. New Jersey
Lidikay, Mrs. E. C..5822 N. Oxford
Link, Mrs. Goethe.3015 N. Meridian
Link, Mrs. W. H....1445 Broadway
Lochry, Mrs. R. L..6150 Crittenden
Lord, Mrs. Glen C.
4455 Washington Blvd.
Lybrook, Mrs. Wm. B.
3636 N. Keystone

M

McBride, Mrs. J. S...7048 Warrick
McCaskey, Mrs. Carl H.
3545 Washington Blvd.
McCormick, Mrs. C. O., Jr.
3843 Central Ave.
McGuff, Mrs. Paul....3545 College
McQuiston, Mrs. R. J.
R. R. 15, Box 385
McTurnan, Mrs. Robert W.
5957 Kingsley Dr.
MacDonald, Mrs. John A.
1408 N. Penn.
MacGregor, Mrs. Donald E.
6080 N. Michigan Rd.
Magennis, Mrs. H. L.
3010 E. 38th, No. 14
Manion, Mrs. Marlow W.
5132 N. New Jersey
Manning, Mrs. K. R..5531 Broadwy
Manning, Mrs. J. C....3121 Sharon
Marshall, Mrs. Cavins R.
6120 N. Michigan Rd.
Martin, Mrs. L. H.....5069 W. 15th
Martz, Mrs. Carl D.
4571 Fall Creek Blvd., S. Dr.
Masters, Mrs. John M....34 E. 46th
Mathew, Mrs. Burleigh W.
346 E. Fall Creek Blvd.
Meiks, Mrs. L. T.....4203 N. Penn.
Mericle, Mrs. Earl W.
4480 N. Meridian
Merrell, Mrs. Paul
270 Buckingham Dr.
Mertz, Mrs. Henrly O.
721 Clarendon Rd.
Micheli, Mrs. Arthur J.
3453 N. Penn, No. 1
Miller, Mrs. R. S.....6140 College
Miller, Mrs. Ray D....3960 Central
Millikan, Mrs. W. J....2620 E. 59th
Mitchell, Mrs. Earl H.
2263 E. Riverside Dr.
Moenning, Mrs. W. P.
7030 N. Penn.
Molt, Mrs. Wm. F...2315 N. Talbot
Montgomery, Mrs. W. F.
246 W. 54th
Moore, Mrs. Ben B..5005 N. Illinois
Moore, Mrs. H. T..R. R. 17, Box 731
Moore, Mrs. R. M..5617 N. Meridian
Morrison, Mrs. L. E..3460 Winthrop
Morton, Mrs. Walter P.
3434 E. Fall Creek Blvd.
Moser, Mrs. Rollin H.
R.R. 16, Box 707
Myers, Mrs. R. V...4723 Broadway

N

Nafe, Mrs. Cleon.5060 N. Meridian
Nay, Mrs. Richard M.....4163 Park
Need, Mrs. Lewis T.
R. R. 19, Box 562
Nehil, Mrs. Lawrence W.
257 W. Westfield Blvd.
Neier, Mrs. O. C...5506 University
Nie, Mrs. Louis W....4815 Guilford
Noble, Mrs. Thomas B., Jr.
4360 N. Penn.
Nolting, Mrs. Henry F.
155 W. Hampton Dr.
Nonte, Mrs. Leo R..4525 Marcy La.
Nourse, Mrs. Myron.5251 Primrose
Nugent, Mrs. Edwin J.
2266 Wyndale Rd.

MARION COUNTY

(Indianapolis—Continued)

O

Ochsner, Mrs. H. C. . . . . 405 E. 45th
Olvey, Mrs. O. N. . . 5533 Broadway
Otten, Mrs. Claude F. . 4456 Central
Ottinger, Mrs. Ross C.
5720 Sunset Lane
Owen, Mrs. John E. . 4429 N. Illinois
Owens, Mrs. Tracy
2823 N. Meridian

P-Q

Pandolfo, Mrs. Harry
529 Markwood Ave.
Patton, Mrs. M. T.
3060 N. Meridian, No. 504
Paulissen, Mrs. G. T. . . . 310 E. 24th
Paynter, Mrs. Morris B. . Robert Rd.
Pearson, Mrs. Lyman R.
5338 Washington Blvd.
Permer, Mrs. Erwin
3018 N. Delaware
Peters, Mrs. Robert J. D.
3203 E. Michigan
Pfaff, Mrs. O. G. . . 4605 N. Meridian
Pierce, Mrs. J. D. . . . . 3159 N. Penn.
Pilcher, Mrs. Jack E.
4601 Graceland
Pollak, Mrs. Lewis . . . 5658 Guilford
Quigley, Mrs. Joseph B.
3610 Watson Rd.

R

Raber, Mrs. Robt. . . 6063 Haverford
Ramsey, Mrs. Frank . . . 325 E. 36th
Reed, Mrs. Philip B.
4131 N. Meridian
Rees, Mrs. R. C. . . . . 5868 E. Wash.
Reid, Mrs. Chas. A. . . 6512 Madison
Ricketts, Mrs. J. W. . 5349 Kenwood
Ritchey, Mrs. Jas. O. . . . . 43 W. 43rd
Robb, Mrs. John A. . 5254 Broadway
Roller, Mrs. C. W. . 2301 Garfield Dr.
Rosenak, Mrs. B. D. . . . . 325 E. 45th
Ross, Mrs. Alexander T.
265 W. Westfield Blvd.
Row, Mrs. D. Hamilton
5214 Grandview Dr.
Ruddell, Mrs. Karl R.
2626 N. Meridian
Rupel, Mrs. Ernest . 5716 N. Penn.
Rust, Mrs. B. K. . . R. R. 14, Box 214
Ryan, Mrs. Glen V.
3168 E. Fall Ck. Pkwy, N. Dr.

S

Sage, Mrs. Russell A. . 8650 College
Salb, Mrs. Max . . . . . 1116 N. Penn.
Sanders, Mrs. Harry M.
3443 N. DeQuincey
Scheier, Mrs. E. W. . . 1706 Prospect
Schneider, Mrs. C. J.
1426 N. LaSalle
Schuchman, Mrs. G. . . . 5837 College
Schuster, Mrs. Dwight . 1830 E. 10th
Seaman, Mrs. C. F. . . . . 3954 Ruckle
Shafer, Mrs. Marion R.
6390 Allisonville Rd.
Sheehan, Mrs. F. G. . . . . 950 Graham
Shimer, Mrs. Will
2152 N. Meridian, No. 105
Shugart, Mrs. Jos. A. . 2620 E. 37th
Shuler, Mrs. Lacey
5868 Washington Blvd.
Shumacker, Mrs. H. B. . . 404 E. 43rd
Sicks, Mrs. Okla W. . . 5609 N. Penn.
Siersdorfer, Mrs. T. N.
6003 W. Washington
Sims, Mrs. J. L. . . . . 3723 N. Gale
Sluss, Mrs. David . 3657 Wash. Blvd.
Smith, Mrs. Lester A.
126 Berkeley Rd.
Smith, Mrs. Roy Lee
R. R. 6, Box 473
Sovine, Mrs. J. W. . . 5311 N. Illinois
Spahr, Mrs. John F., Jr.
3845 N. Meridian
Sparks, Mrs. Alan L. . . 4310 Central
Spaulding, Mrs. Jos. J. . 112 W. 44th
Sputh, Mrs. C. B., Jr. . 3662 N. Gale
Sputh, Mrs. Carl B., Sr.
5735 Central
Stanley, Mrs. John
3146 Washington Blvd.
Stayton, Mrs. Chester A., Sr.
5876 Central
Stephens, Mrs. Donald . 4049 College
Stevens, Mrs. Sydney L.
3430 N. Temple
Stoelting, Mrs. Virgil . 3370 N. Gale
Stone, Mrs. A. T. . . . 5727 Broadway
Stucky, Mrs. E. K. . 3602 Watson Rd.
Stygall, Mrs. J. H.
4311 N. Meridian
Sudranski, Mrs. Herbert F.
3614 Guilford
Sutton, Mrs. W. E.
1215 N. Alabama
Swan, Mrs. J. R. . 5402 N. Delaware

T

Talbott, Mrs. Dan E. . 5906 Rosslyn
Tanner, Mrs. Henry S.
5144 N. Delaware
Taylor, Mrs. Clifford M.
5938 Crittenden
Taylor, Mrs. F. W. . . . . 40 E. 43rd
Teague, Mrs. Frank W.
R. R. 14, Box 216
Terry, Mrs. W. B. G., Jr.
3896 N. Sherman Dr.
Tether, Mrs. J. Edward
2206 Lafayette Rd.
Tharpe, Mrs. Ray . . . . Marott Hotel
Thatcher, Mrs. Hugh K., Jr.
745 W. 44th
Thomas, Mrs. Lowell
28 W. Hampton Dr.
Thomas, Mrs. Morris E.
5207 N. New Jersey
Thompson, Mrs. Charles E.
6038 N. Olney
Thompson, Mrs. John V.
R. 14, Box 122T
Thornburg, Mrs. K. E.
4416 Carrollton
Thurston, Mrs. A. L. . . . 421 E. 41st
Tinney, Mrs. W. E. . 3902 Carrollton
Tinsley, Mrs. Walter B.
3314 Carrollton
Torrella, Mrs. J. A. . . . 4918 W. 14th
Toumey, Mrs. F. L.
4450 Marcy Lane, No. 109
Travis, Mrs. J. C. . . 6268 Broadway
Trusler, Mrs. Harold M.
6150 N. Penn.
Tuchman, Mrs. J. N. . 4525 Indianola
Tucker, Mrs. W. S. . . 5421 Indianola

V

VanMeter, Mrs. C. Powell
1925 N. Emerson
Vandivier, Mrs. Robert M.
4732 Cornelius
VanOsdol, Mrs. H. A.
43 Hampton Dr.
Voyles, Mrs. Charles F.
4150 N. Meridian

W

Waldo, Mrs. J. T. . . . 8383 N. Illinois
Walker, Mrs. Frank C.
5563 N. Penn.
Waller, Mrs. John . . 5242 N. Illinois
Walther, Mrs. Joseph E.
3641 Watson Rd.
Warvel, Mrs. J. H. . . . R. 17, Box 312
Waterman, Mrs. John H.
5435 N. Capitol
Welcher, Mrs. Frank
R. R. 12, Box 232W
Weller, Mrs. Charles A.
3720 N. Delaware
West, Mrs. J. L. 5261 Woodside Dr.
Westfall, Mrs. B. K., Jr.
6601 College
Westfall, Mrs. J. B. . . . 3618 E. 34th
White, Mrs. Donald J.
5430 N. Delaware
Whitehead, Mrs. J. M.
2201 Nowland
Wilkens, Mrs. I. W.
4816 Pleasant Run Pkwy.
Williams, Mrs. Howard
5105 Indianola
Wilson, Mrs. O. R. . . . . 512 E. 28th
Winter, Mrs. Mathew
4044 Carrollton
Wishard, Mrs. W. N.
4150 N. Illinois
Wise, Mrs. Wm. . . . . 4934 N. Penn.
Wolfram, Mrs. D. J . 5872 Broadway
Wood, Mrs. Geo. . . 5122 Wash. Blvd.
Woodard, Mrs. A. S. . . 5449 N. Penn.
Wright, Mrs. J. W. Jr.,
2110 W. 42nd
Wyttenbach, Mrs. F. C. . . . . R. R. 2
Wyttenbach, Mrs. J. E.
5509 Kenwood

Y

Young, Mrs. J. M. . 4525 Marcy Lane
Young, Mrs. J. W. . . 5815 Primrose
Young, Mrs. W. C. . . . 3215 Medford

New Augusta

Asher, Mrs. Ernest O. . . . . Box 4
Asher, Mrs. James W.
Brown, Mrs. David . . . . Lakeside Dr.
Harris, Mrs. C. B.
R.R. 1, Box 375A
Spivey, Mrs. R. J. . . . . R. R. 1
Brown, Mrs. D. W., Jr. . . . . W. 86th

Stephens, Mrs. K. H. . . . . Lawrence
Arnold, Mrs. M. F. . . New Palestine
Grove, Mrs. E. G.
242 W. Broadway, Shelbyville
Burkhardt, Mrs. Boyd
328 N. West St., Tipton
Jones, Mrs. Geo. L. . . . . Wanamaker
Bailey, Mrs. L. S. . . . . Zionsville

MARSHALL COUNTY

Bowen, Mrs. Otis R. . . . . Bremen
Stine, Mrs. Marshall . . . . . Bremen
Witham, Mrs. R. L. . . . . Culver

MARSHALL COUNTY
(Continued)

Plymouth

Eley, Mrs. T. C. . . . 801 N. Michigan
Irey, Mrs. P. R. . 1020 Lincolnway E.
Klingler, Mrs. M. O. . 1111 Ferndale
Knott, Mrs. Harry
1017 N. Michigan
Kubley, Mrs. James
Pomeroy, Mrs. R. K. . . . . 1400 Park
Robertson, Mrs. James
Stephens, Mrs. R. C.
919 N. Michigan
Vore, Mrs. L. W. . 1301 N. Michigan

MIAMI COUNTY

Line, Mrs. Homer . . . . . Chili
Frybarger, Mrs. S. S. . . . . Converse
Sennett, Mrs. Wm. K. . . . . Macy
Waite, Miss Margaret . . . . . Macy
Rendel, Mrs. H. E. . . . . Mexico

Peru

Andrews, Mrs. E. H. . . 172 W. Third
Baldwin, Mrs. C. F.
17½ S. Huntington Rd.
Barnett, Miss Helen . . . . 109 W. 7th
Berkebile, Mrs. J. B. . . . . 15 W. 6th
Carl, Mrs. Omer . . . . . 128 W. Third
Eikenberry, Mrs. B. F. . . . 28 W. 6th
Ewing, Miss Ethel . . . . Dukes Hosp.
Freezee, Mrs. J. A. . . . . 212 E. Main
Johnson, Mrs. O. B. . . . . 563 W. 6th
Lynn, Mrs. F. M. . . . . 258 W. Main
Malouf, Mrs. S. D. . . . . 359 W. Third
McDowell, Mrs. Anna . 53 E. Second
Wagner, Mrs. M. L. . . . . R. R. 4
Wildman, Mrs. R. E. . . . . R. R. 2
Yarling, Mrs. Francis . . 117 E. Fifth

MONTGOMERY COUNTY

Stout, Mrs. Harry . . . . . Colfax

Crawfordsville

Alexander, Mrs. S. J. . . . . 202 West
Ball, Mrs. T. Z. . . . . 401 S. Wash.
Burks, Mrs. J. E. . . . . 411 S. Walnut
Cooksey, Mrs. T. L. . . . 206 Marshall
Cornell, Mrs. R. A. . . . 521½ E. Main
Daugherty, Mrs. F. N. . 415 W. Main
Griffith, Mrs. J. B. . . . . 218 S. Green
Haller, Mrs. T. C. . . . . 508 W. Main
Humphreys, Mrs. J. W.
206 Woodlawn
Kinnaman, Mrs. H. A.
1107 W. Wabash
Kirtley, Mrs. J. M. . . . . 201 S. Grant
Lingeman, Mrs. B. J. . . 203 Wallace
Millis, Mrs. R. J. . . . . 8 Mills Place
Mount, Mrs. W. M. . . 1417 W. Main
Pierson, Mrs. R. H. . . . . 305 E. Main
Peacock, Mrs. N. F. . 107 Vernon Ct.
Pollom, Mrs. R. R. . . . . 506 S. Water
Sharp, Mrs. J. L. . . . . 1403 E. Main
Taylor, Mrs. W. M. . . 410 S. Water
Wallace, Mrs. H. C.
107 W. Jefferson

Otten, Mrs. R. R. . . . . Darlington
Schaaf, Mrs. Alvin R. . . Jamestown
Smith, Mrs. B. J. . . . . Kingman
Blix, Mrs. Fred . . . . . Ladoga
Denny, Mrs. F. T. . . . . Ladoga
Walterhouse, Mrs. H. H. . . . Ladoga
Davis, Mrs. W. H. . . . . New Market
Kindell, Mrs. H. D. . New Richmond
Gwaltney, Mrs. L. F. . . . . Roachdale
Richards, Mrs. E. E. . . . Russellville
Himebaugh, Mrs. G. J . Veedersburg
Rusk, Mrs. H. M. . . . . Wallace
Johnson, Mrs. Dale . . . . Waynetown
Parker, Mrs. C. B. . . . . Wingate

MORGAN COUNTY

Martinsville

Dickens, Mrs. Karl . . 95 W. Jackson
Eisenberg, Mrs. David
340 E. Cunningham
Gray, Mrs. Leon . . . . . 260 N. Ohio
Pitkin, Mrs. Edw. . . . . 309 E. Wash.
Pitkin, Mrs. McKendree
440 E. Wash.
Sweet, Mrs. A. D. . . . 260 N. Wayne
Willan, Mrs. H. R. . . 109 S. Jefferson

Comer, Mrs. Chas. . . . . Mooresville
Comer, Mrs. Kenneth . . Mooresville
VanBokkelen, Mrs. R. W.
Mooresville

NORTHEASTERN ACADEMY

Nash, Mrs. J. R. . . . . Albion
Covell, Mrs. H. M. . . . . Auburn
Mettler, Mrs. D. C. . . . . Auburn
Nugen, Mrs. Harold . . . . . Auburn
Hathaway, Mrs. C. B. . . . . Butler
Jinnings, Mrs. L. B. . . . . Garrett
Kantzer, Mrs. F. B. . . . . Garrett
Reynolds, Mrs. D. M. . . . . Garrett
Reynolds, Mrs. Perry . . . . . Garrett
Alford, Mrs. James . . . . . Hamilton
Bryan, Mrs. R. E. . . . . Kendallville
Gutstein, Mrs. R. R. . . . Kendallville
Hardy, Mrs. F. C. . . . . Kendallville
Lawson, Mrs. I. H. . . . . Kendallville
Munk, Mrs. C. E. . . . . Kendallville
Seybert, Mrs. J. D. . . . . Kendallville
Williams, Mrs. H. O. . . . Kendallville
Stultz, Mrs. Q. F. . . . . Ligonier
Fipp, Mrs. A. L. . . . . Rome City
Coleman, Mrs. Floyd . . . . . Waterloo
Showalter, Mrs. J. R. . . . . Waterloo
Pulskamp, Mrs. B. H. . . Wolcottville
Luckey, Mrs. R. C. . . . . Wolf Lake

OWEN-MONROE COUNTIES

Bloomington

Austin, Mrs. Rayburn . 114 S. Grant
Baxter, Mrs. Neal . . . . 515 N. Wash.
Borland, Mrs. Ray . . . . Moores Pike
Buckingham, Mrs. Richard
705 S. Fess
Fowler, Mrs. Richard
807 S. Henderson
Geiger, Mrs. Dillon . . . . N. Fee Lane
Holland, Mrs. D. J. . . 313 N. College
Holland ,Mrs. Chas. . . 712 N. Wash.
Holland, Mrs. Frank . 514 N. College
Holland, Mrs. J. E. P. . . 801 E. 8th
Karsell, Mrs. W. A. . . . 1401 E. 10th
Lyons, Mrs. Robert . . Unionville Rd.
Marchant, Mrs. Clarence
350 S. College
Middleton, Mrs. Thos. . . . E. Seventh
Myers, Mrs. B. D. . . . 424 N. Walnut
Owens, Mrs. Walter . . . Hoosier Cts.
Poolitson, Mrs. Geo. . 1902 Maxwell
Prosser, Mrs. Wm. . . . 1211 Maxwell
Ramsey, Mrs. Hugh . . . 619 E. First
Reed, Mrs. Wm. . . . . 1215 Atwater
Rogers, Mrs. Floyd . . 804 E. Eighth
Ross, Mrs. Ben . . . . Martinsville Rd.
Schell, Mrs. H. D. . . . 801 E. Eighth
Smith, Mrs. Herschel
Martinsville Rd.
Spencer, Mrs. Beaufort . . 816 E. 8th
Stangle, Mrs. Wm. . . . Nashville Rd.
Thomas, Mrs. Harry . 1717 E. Third
Topolgus, Mrs. Jas. . . 603 N. Walnut
Wilson, Mrs. T. L. . 301 E. Kirkwood

Smith, Mrs. Paul . . . . . Ellettsville
Stouder, Mrs. Chas. . . . . Gosport
Brown, Mrs. Marcel
358 Wash. St., Spencer
Smith, Mrs. F. R.
448 Lovers Lane, Spencer

PARKE-VERMILLION COUNTIES

Brown, Mrs. R. E. . . . . Cayuga
Casebeer, Mrs. Paul B. . . . . Clinton
Evans, Mrs. F. J. . . . . Clinton
Gerrish, Mrs. W. D. . . . . Clinton
Kercheval, Mrs. J. M. . . . . Clinton
Phipps, Mrs. Elwood . . . . . Clinton
Rosenfeld, Mrs. N. B. . . . . Clinton
Shaff, Mrs. Zona . . . . . Clinton
White, Mrs. C. S. . . . . Clinton
White, Mrs. I. D. . . . . Clinton
Myers, Mrs. W. C. . . . . Dana
Warren, Mrs. Bradford . . Marshall
Britton, Mrs. W. D. . . . . Montezuma
Saunders, Mrs. J. L. . . . . Newport
Johnson, Mrs. W. A. . . . . Perrysville
Bloomer, Mrs. J. R. . . . . Rockville
Bloomer, Mrs. R. S. . . . . Rockville
Dowell, Mrs. Emil . . . . . Rockville
Harstad, Mrs. C. . . . . Rockville
Merrell, Mrs. B. M. . . . . Rockville
Pirkle, Mrs. H. B.
State San., Rockville
Staff, Mrs. R. A.
State San., Rockville

PERRY COUNTY

Bush, Mrs. H. R. . 6th St., Cannelton
Westerbeck, Mrs. Chas . St. Meinrad

Tell City

Dome, Mrs. H. S. . . . . 147 Eleventh
Dukes, Mrs. D. A. . . . . 521 Main
Coultas, Mrs. P. J. . . . . 809 Main
Glenn, Mrs. F. C. . . . . 436 Main
James, Mrs. N. A. . . . . 740 Ninth
Lashley, Mrs. D. L. . . . . 600 Ninth
Lally, Mrs. B. V. . . . . 622 Main
Neifert, Mrs. N. L. . . . . S. Blum
Snyder, Mrs. Earl L. . . . . Troy

PORTER COUNTY

Chesterton

Griffin, Mrs. J. F. . . . . 134 Park
Hall, Mrs. T. C. . . . . 600 E. Morgan

PORTER COUNTY

(Continued)

Valparaiso

Brown, Mrs. J. C. . . . . 458 Park
Davis, Mrs. C. E. . . . . 202 Indiana
DeGrazia, Mrs. E. G. . 157 McIntyre
DeWitt, Mrs. C. H. . . . . 836 LaPorte
Douglas, Mrs. G. R. . . . . 404 Wash.
Eades, Mrs. Ralph
501 E. Lincolnway
Makovsky, Mrs. Theodore
909 Institute
Miller, Mrs. E. H. . . . . 608 Union
Seipel, Mrs. H. O. . . . 302 Lafayette
Vietzke, Mrs. P. C. F. . . 58 Jefferson

PULASKI-STARKE COUNTIES

Ferguson, Mrs. J. F. . . . . Hamlet
Henry, Mrs. H. J. . . . . Knox
Farabee, Mrs. C. R. . . . . N. Judson
Fisher, Mrs. Nora . . . . . N. Judson
Matthews, Mrs. J. R. . . . . N. Judson
Carneal, Mrs. T. E. . . . . Winamac
Halleck, Mrs. H. J. . . . . Winamac
McCaskey, Mrs. G. H. . . . . Winamac
Thompson, Mrs. W. R. . . . Winamac

PUTNAM COUNTY

Veach, Mrs. L. W. . . . . Bainbridge
Veach, Mrs. Richard . . . . Bainbridge
Gray, Mrs. Clyde . . . . . Cloverdale

Greencastle

Detloff, Mrs. F. R. . . 201 W. Walnut
Dobbs, Mrs. O. R. . . . . R. F. D.
Fuson, Mrs. W. J. . . . . Northwood
Hutcheson, Mrs. W. R. . . . E. Wash.
Johnson, Mrs. J. B. . . 207 E. Poplar
Parker, Mrs. Geo. F. . . . . R. F. D.
Rhea, Mrs. G. D. . . . . 126 E. Wash.
Schwaucker, Mrs. C. M. . Northwood
Steele, Mrs. Dick . . . . . Northwood
Tennis, Mrs. George . . . . S. Jackson
Wiseman, Mrs. V. E. . . . Durham St.

Gwaltney, Mrs. L. F. . . . . Roachdale

RUSH COUNTY

McNabb, Mrs. G. B. . . . . Carthage
Worth, Mrs. C. W. . . . . Milroy

Rushville

Anderson, Mrs. Sam . . . . . R. R. 4
Atkins, Mrs. C. C. . . 401 N. Perkins
Corpe, Mrs. K. F. . . . . R. R. 4
Dean, Mrs. D. I. . . . . 310 E. Fifth
Denny, Mrs. M. H. . . 124 E. Twelfth
Ellis, Mrs. D. W. . . . . 110 W. Eighth
Frazier, Mrs. John . . . . . 210½ E. 7th
Green, Mrs. F. H. . . . 516 N. Morgan
Johnson, Mrs. Robert
841 N. Harrison
Kennedy, Mrs. R. O. . . 1004 N. Main
Kiplinger, Mrs. Jean
838 N. Harrison
Lee, Mrs. John . . . . . 914 N. Morgan
Morgan, Mrs. Helen . 327 N. Morgan
Nutter, Mrs. W. H. 1003 N. Morgan
Shanks, Mrs. R. E. . 1110 N. Morgan
Sipes, Mrs. Anna . . . . . 222 W. Third

SHELBY COUNTY

Nigh, Mrs. Rufus . . . . . Fairland
Davis, Mrs. John . . . . . Flatrock
Miller, Mrs. Frank . . . . . Morristown

Shelbyville

Barnum, Mrs. Emerson
Gehres, Mrs. Robt. . . . . 610 Shelby
Inlow, Mrs. H. H. . . . . N. Harrison
Inlow, Mrs. W. D. . . . Springhill Rd.
Miller, Mrs. R. C. . . . . W. Mechanic
Phares, Miss Frances . . S. Harrison
Richard, Mrs. Norman . . . W. Wash.
Scott, Mrs. Charles . . . . . R. R. 2
Scott, Mrs. V. B. . . . . R. R. 2
Silbert, Mrs. David . . . . . West St.
Spindler, Mrs. Robert
165 W. Mechanic
Tindall, Mrs. W. R. . 616 S. Harrison

ST. JOSEPH COUNTY

Bolka, Mrs. B. J. . . . . Eagle Point,
Diamond Lake, Cassopolis, Mich.

Mishawaka

Ganser, Mrs. R. A. . . . . 409 E. Third
Goethals, Mrs. C. J.
602 Lincolnway W.
Kamm, Mrs. B. A.
618 Lincolnway W.
Logan, Mrs. F. W.
304 Lincolnway E.
McDonald, Mrs. R. M.
E. Jefferson Rd.
Orr, Mrs. W. R. . . . . 124 S. Race
Proudfit, Mrs. C. H. . . 1135 E. Third
Sirlin, Mrs. E. M.
419 Lincolnway W.
Spalding, Mrs. W. L. . . 617 Webster
Templeton, Mrs. Ames
914 W. Lawrence
Walters, Mrs. C. E. . . . 111 S. Cedar
Ward, Mrs. Jas. W.
316 Lincolnway E.
Whitlock, Mrs. M. E. . . . . 123 W. 4th
Wurster, Mrs. H. C. . . . 221 E. Third
Wyland, Mrs. B. J. . . . . 510 Calhoun
Zimmer, Mrs. H. J. . . 333 Edgewater

South Bend

Arisman, Mrs. R. K. . 1615 E. Colfax
Bechtold, Mrs. S. E. . . . 1825 Wilber
Bennett, Mrs. J. R. . 1072 Woodward
Berke, Mrs. R. D. . . . . 2510 Erskine
Biasini, Mrs. B. A.
403 Dixie Hwy., N.
Bickel, Mrs. David A.
1335 E. Wayne, N.
Birmingham, Mrs. P. J.
1126 E. Irvington
Bixler, Mrs. L. C. . . . 506 E. Altgeld
Blackburn, Mrs. Erwin
1343 E. LaSalle
Bodnar, Mrs. L. M. . . . . 810 Arch
Borough, Mrs. L. D. . 1726 McKinley
Buchanan, Mrs. W. D. 1351 E. South
Buechner, Mrs. F. W.
603 W. Marion
Bussard, Mrs. C. F.
329 W. Madison
Bussard, Mrs. F. W.
1332 E. Monroe
Carter, Mrs. F. R. N.
2000 E. Jefferson
Cassady, Mrs. J. V. . . 110 Napoleon
Chambers, Mrs. Wm. R.
1335 E. South
Clark, Mrs. Wm. H.
1336 E. Wayne, N.
Colip, Mrs. G. D. . . . . 300 David
Cook, Mrs. G. C. . . 1433 Mishawaka
Custer, Mrs. E. W. . . . . Laurel Rd.
Denham, Mrs. Robt. H.
332 W. Navarra
Dietl, Mrs. E. L. . . 216 S. Coquillard
Dodd, Mrs. R. D. . . . . 1017 Kinyon
Donnelly, Mrs. Everett
R. R. 6, Box 518, Miami Rd.
Duggan, Mrs. J. A. . . 110 Peachway
Dunlap, Mrs. D. L.
123 W. North Shore Dr.
Edwards, Mrs. B. E.
1341 E. Wayne, N.
Egan, Mrs. S. L. . . 944 Riverside Dr.
Ellison, Mrs. Alfred . Dragoon Trail
English, Mrs. J. P. . . . . 1317 Wall
Ericksen, Mrs. L. G.
1322 E. Wayne, N.
Faltin, Mrs. L. . . . 302 S. Coquillard
Feldman, Mrs. Max . . . . 1921 Miami
Filipek, Mrs. W. J.
2513 Lincolnway, W.
Firestein, Mrs. B. Z. . 508 W. Colfax
Firestein, Mrs. Ray
3201 Mishawaka
Fish, Mrs. C. M. . . . . 119 Marquette
Fish, Mrs. E. C. . . . . 1264 E. Colfax
Fisher, Mrs. L. F. . . 1717 E. Colfax
Frank, Mrs. L. L. . 534 N. Lafayette
Frash, Mrs. D. W.
1235 E. Wayne, S.
Friedman, Mrs. M. S.
1420 E. Ewing
Gates, Mrs. G. E.
411 W. North Shore Dr.
Giordano, Mrs. A. S. . . 1222 25th St.
Green, Mrs. G. F. . . . 1515 E. Wayne
Green, Mrs. N. E. . . . . 1844 Kessler
Grillo, Mrs. Don . . . 1832 W. Adams
Haley, Mrs. P. E. . . 313 E. Pokagon
Hamilton, Mrs. C. O. . . 814 Turnock
Harmon, Mrs. V. E.
3221 Mishawaka
Helman, Mrs. H. E. . . 1428 E. Wash.
Hewitt, Mrs. M. I.
210 S. Coquillard
Hilbert, Mrs. J. W. . . 410 W. Wash.
Hillman, Mrs. M. W.
1516 Marquette
How, Mrs. L. E. . . 111 N. LaFayette
Hyde, Mrs. C. C. . . . . 1521 E. Colfax
Karn, Mrs. J. W. . . . . 425 Napoleon
Klahr, Mrs. E. E. . . . 1422 McKinley
Lane, Mrs. W. H. . . . . 845 Park
Langenbahn, Mrs. C. J.
1339 E. South
Lionberger, Mrs. J. R.
1136 Sunnymede
Liss, Mrs. Emanuel
1612 E. Madison
Liston, Mrs. Ann
415 St. Joseph Bk. Bldg.
Ludwick, Mrs. H. A.
2730 Lincolnway W.
Luthy, Mrs. K. R. . 1204 E. Bronson
McCraley, Mrs. W. J.
2420 Erskine
Metcalfe, Mrs. G. E.
1209 E. Wayne, N.
Mikesch, Mrs. W. H. . 1315 E. South
Miller, Mrs. M. K. . 1714 E. Madison

ST. JOSEPH COUNTY

(South Bend—Continued)

Miller, Mrs. W. E. . . . 714 W. Wash.
Murphy, Mrs. E. C.
1411 Sunnymede
Nelson, Mrs. F. D.
414 Willow Run Rd.
Nelson, Mrs. R. E. . 1340 Sunnymede
Olson, Mrs. K. L. . . . 226 Marquette
Parke, Mrs. D. D. . . . . 828 Sorin
Pauszek, Mrs. T. B. . 916 Riverside
Petrass, Mrs. Andrew
Liberty Hwy.
Palin, Mrs. George . . 2280 Ponader
Pyle, Mrs. H. D. . . 115 N. Sunnyside
Rodin, Mrs. H. H. . 1119 Sunnymede
Rosenheimer, Mrs. G. M.
1425 E. Woodside
Rubens, Mrs. Eli . . 1331 E. Victoria
Rudicel, Mrs. Max . . . . 808 Turnock
Rudolph, Mrs. C. J.
2016 E. Madison
Sanderson, Mrs. R. B.
1331 Sunnymede
Sandock, Mrs. I. . . . . 125 W. Marion
Sandock, Mrs. L. F.
310 S. Sunnyside
Sandoz, Mrs. H. H.
239 S. Hawthorne
Sandoz, Mrs. L. A.
304 S. Twyckanham
Savery, Mrs. C. E. . . R.R. 5, Box 645
Schiller, Mrs. H. A. . . 1813 E. Cedar
Scott, Mrs. F. M. . . . . 1861 Adams
Selby, Mrs. K. E.
1327 E. Wayne, N.
Sensenich, Mrs. R. L.
120 W. LaSalle
Stiver, Mrs. D. D. . . . . 1329 Belmont
Stratigos, Mrs. J. S. . 2602 S. Bend
Thompson, Mrs. J. M. . . 1618 Cedar
Thornton, Mrs. M. J. . . . Miami Rd.
Traver, Mrs. P. C. . 1010 Riverside
Weiss, Mrs. Eugene . . 2517 S. Mich.
Wilson, Mrs. J. M.
1403 E. Jefferson
Wygant, Mrs. M .D.
1232 Lincolnway W.

TIPPECANOE COUNTY

Lafayette

Clauser, Mrs. A. C. . . . . 2020 Union
DuBois, Mrs. R. B. . . . . 12 S. 30th
Flack, Mrs. R. A. . . . . 627 Central
Gery, Mrs. Richard . . . 1507 Central
Graham, Mrs. T. G. . . . . 1213 Wea
Harshman, Mrs. M. L. . . 700 Brown
Harter, Mrs. E. B. . . . . 1119 Adams
Johnson, Mrs. H. S. . . . . 1405 S. 5th
Jones, Mrs. D. M. . . . . 1406 S. 18th
Karberg, Mrs. R. J. . . 1600 Potomac
Klepinger, Mrs. H. E. . . 909 N. 21st
McAdams, Mrs. H. B. . . 1411 Sunset
McClelland, Mrs. D. C.
1021 Highland
Miller, Mrs. R. E. . . . . 2055 S. 9th
Neumann, Mrs. K. O. . . 1410 S. 18th
Pyke, Mrs. F. L. . . . . 532 S. 9th
Ratcliff, Mrs. Frank . . . . 612 S. 28th
Rothrock, Mrs. P. W. . . . 2061 S. 9th
Sholty, Mrs. Wm. . . . . R. R. 8
Trout, Mrs. C. J. . . . . 800 State
VanReed, Mrs. Earl . . . . . 806 S. 9th
Vermilya, Mrs. R. W. . . . 1028 Tulip
Washburn, Mrs. W. W. . . 425 Asher

McClure, Mrs. S. E. . . . . Monon
Mitchell, Mrs. E. T. . . . . Romney
Babb, Mrs. Forrest J. . . . . Stockwell

West Lafayette

Bayley, Mrs. Wm. E. . . . . 622 Rose
Burkle, Mrs. J. C. . . . 121 University
Calvert, Mrs. R. R. . . . . 308 Park
Currie, Mrs. R. W. . . . . 929 Garden
Eaton, Mrs. M. J. . . 425 Forest Hills
Ferguson, Mrs. W. B. . . . 704 Bexley
Holladay, Mrs. L. J.
227 S. Salisbury
McFadden, Mrs. J. M.
240 S. Chauncey
Schuck, Cecilia . . . . . 907 Third
Spurlock, Mrs. F. H.
209 Northwestern
Stahl, Mrs. E. T. . . . . 324 Park
VanBuskirk, Mrs. E. L.
1301 Ravinia

VANDERBURGH COUNTY

Purcell, Mrs. Jack H. . . . . Boonville
Stover, Mrs. W. C. . . . . Boonville

Evansville

Acre, Mrs. R. R. . . . . 2311 Lincoln
Adler, Mrs. Ray . . . . . 427 Lewis
Allenbaugh, Mrs. . 3218 E. Mulberry
Anderson, Mrs. D. W.
805 E. Powell
Antes, Mrs. Earl . . . . . 359 Drier
Austin, Mrs. Eugene W.
2263 Bayard Pk. Dr.
Baker, Mrs. C. S. . . . 1931 E. Powell
Baker, Mrs. J. S. . . 2670 Stringtown
Barclay, Mrs. I. C. . . . . 1215 Parrot
Barnhart, Mrs. W. T.
1211 Ravenswood
Bennett, Mrs. A. P.
2507 E. Blackford
Brockmole, Mrs. A. W. . . . 700 Mary
Brown, Mrs. R. L. . . 1961 E. Powell
Browne, Mrs. W. A. . . . 1304 E. Gum
Bryan, Mrs. S. L. . 3211 E. Mulberry
Buchholz, Mrs. R. R.
2812 Bellemeade
Buikstra, Mrs. C. R. . Darmstadt Rd.
Burnikel, Mrs. R. H.
960 S. Rotherwood
Cacia, Mrs. John . . . . . 2301 Vogel
Caldwell, Mrs. W. C. . . . 643 College
Clements, Mrs. A. F.
Outer Bellemeade
Clouse, Mrs. Paul
2508 E. Blackford
Cockrum, Mrs. W. M . 1414 Parkside
Coleman, Mrs. J. E. . 1515 Sweetzer
Combs, Mrs. H. T. . R. R. 1, Box 561
Combs, Mrs. P. B. . . . 4035 Lincoln
Corcoran, Mrs. P. J. V. . . . Plaza Dr.
Crane, Mrs. A. L.
Box 837, Kratzville Rd.
Crawford, Mrs. James . 2024 Lincoln
Crevello, Mrs. A.J. . . 957 E. Powell
Crimm, Mrs. P. D. . . . Boehne Hosp.
Cullnane, Mrs. C. W.
3020 Mt. Vernon
Daves, Mrs. W. L. . . . . 708 College
Denzer, Mrs. E. K.
1509 S. E. Boulevard
Denzer, Mrs. W.O. 923 Bellemeade
Dieckman, Mrs. H. S. . Harrelton Ct.
Diefendorf, Mrs. C. F.
716 N. St. Joseph
Dodd, Mrs. R. K.
New Green River Rd.
Dycus, Mrs. W. A. . . . 3309 W. Mich.
Dyer, Mrs. W. C. . . . Colonial Apt. C
Dyer, Mrs. W. K. . . . . 812 St. James
Ehrich, Mrs. Wm. S.
1500 S. Kentucky
Eisterhold, Mrs. John
R. R. 13, Koring Rd.
Engel, Mrs. E. L. . . . . 852 E. Gum
Faul, Mrs. H. J. . . . . 725 S. Willow
Fickas, Mrs. Dallas . . . . 913 E. Gum
Fisher, Mrs. Wm. C.
1319 S. Kentucky
Fitzsimmons, Mrs. E. L.
500 S. Boeke Rd.
Flinn, Mrs. J. H. . . . . 551 Ruston
French, Mrs. W. G.
Box 2006, Station D
Garland, Mrs. E. A. . . . . Plaza Dr.
Gaul, Mrs. L. E. . . . . 508 Boeke
Grant, Mrs. J. H. . . . . 2316 E. Mich.
Greip, Mrs. A. H.
2024 Lincoln, Apt. A-1
Hammond, Mrs. R. C.
Mt. Auburn Apts.
Hare, Mrs. D. M. . . . 3021 E. Powell
Hartley, Jr., Mrs. C. A.
1300 S. Kentucky
Hartz, Mrs. Minton . . . . . 854 Lodge
Healy, Mrs. W. F. . . . 722 S. Willow
Hefti, Mrs. Karl . . . . Eastridge Dr.
Heinrich, Mrs. Weston
2012 E. Chandler
Helper, Mrs. Morton
458 Ruston
Herzer, Mrs. C. C . 2020 E. Mulberry
Huggins, Mrs. Victor . 520 S. Alvord
Hyatt, Mrs. G. T. . . 815 E. Chandler
Johnson, Mrs. S. L.
750 S. Frederick
Kessler, Mrs. R .D. . . . . 1003 First
Kiechle, Mrs. F. L. . . Boehne Hosp.
Kleindorfer, Mrs. R. L.
615 S. Willow
Lang, Mrs. S. C. . . . . Outer Lincoln
Laubscher, Mrs. Clarence . . . R.R. 12
Lawrence, Mrs. J. C.
1362 E. Chandler
Leich, Mrs. C. F. 306 SE Riverside
Leslie, Mrs. E. T. . . . . 2923 E. Gum
Logan, Mrs. J. R. . . . . 503 First
Lynch, Mrs. P. V . 216½ SE Riverside
Macer, Mrs. C. G. . . . 280 0W. Penn.
MacKenzie, Mrs. Pierce
907 E. Gum
McCool, Mrs. J. H. 920 E. Mulberry
McDonald, Mrs. J. D. . . 317 Wabash
Mehl, Mrs. R. A. . . 3103 Bellemeade
Meyer, Mrs. K. T. . . . . 399 S. Alvord
Miller, Mrs. L. B. . . 417 Kelsey St.
Miller, Mrs. M. J.
960 Spring St., Apt. D
Miller, Mrs. R. J. . . . 1563 S. Spring
Mills, Mrs. Fred . . . . . 555 S. Kelsey
Mino, Mrs. Victor . . . Newburgh Rd.
Moehlenkamp, Mrs. C. E.
305 E. Iowa
Neucks, Mrs. Howard . 303 Chandler
Newman, Mrs. Alvin . Harrelton Ct.
Niedermayer, Mrs. A. J.
2801 Bayard Pk. Dr.
Pollard, Mrs. Walter . . 1230 SE 2nd

VANDERBURGH COUNTY

(Evansville—Continued)

Porro, Mrs. F. W.....326 Polster
Present, Mrs. J. D.....201 Parker
Pugh, Mrs. Willis.....559 Ruston
Ratcliffe, Mrs. A. W.....510 SE 1st
Ravdin, Mrs. B. D.....706 Sunset
Ravdin, Mrs. Marcus
1666 Bayard Pk. Dr.
Reich, Mrs. C. E....1209 N. Fulton
Richey, Mrs. Clifford.400 S. Kelsey
Rininger, Mrs. H. C....1920 Wash.
Ritchie, Mrs. W. D....Feltman Dr.
Ritz, Mrs. A. S...1375 E. Chandler
Rosenblatt, Mrs. B. B.
626 St. James
Rossow, Mrs. R. J....953 E. Powell
Ruddick, Mrs. H. C.
845 Ravenswood
Rusche, Mrs. Henry
1636 E. Franklin
Russell, Mrs. R. H.
2519 E. Blackford
Schirmer, Mrs. R. H.
2710 Hartmetz
Schneider, Mrs. C. P.
2924 W. Maryland
Schreifer, Mrs. V. V..390 S. Alvord
Slaughter, Mrs. H. C.800 St. James
Slaughter, Mrs. J. C....622 College
Springstun, Mrs. W. R.2516 Adams
Stanton, Mrs. Harmon.701 College
Steele, Mrs. P. W..306 S. Weinbach
Sterne, Mrs. J. H.....741 E. Powell
Stork, Mrs. U. F.....414 S. Kelsey
Tweedall, Mrs. D. C.
Mt. Pleasant Rd.
Tweedall, Mrs. D. G....2202 W. Ill.
Underwood, Mrs. J. B..1408 Lincoln
Visher, Mrs. J. W....1066 Madison
Weiss, Mrs. H. G....1014 E. Powell
Welborn, Mrs. M. B.
Mt. Auburn Rd.
Wesson, Mrs. T. H....814 Lombard
Wilhelmus, Mrs. G. M.
1650 E. Walnut
Wilhelmus, Mrs. W. M.
R. R. 7 (St. Wendell)
Willison, Mrs. G. W.
411 Lincoln Pk. Dr.
Wilson, Mrs. J. D.....1207 E. Park
Wilson, Mrs. Ralph.....804 Wash.
Wishart, Mrs. S. W....1105 SE 1st
Wood, Mrs. W. H...3306 E. Powell
Wynn, Mrs. J. F.....651 Weinbach
Yunker, Mrs. P. E.....2418 Lincoln
Zimmerman, Mrs. Harold
1030 McArthur Circle

Oliphant, Mrs. Frank..Mt. Vernon
Durkee, Mrs. M. S.
R. R. 2, Newburgh
Faith, Jr., Mrs. I. L.....Newburgh
Wilhelmus, Mrs. K. C...Newburgh
Ropp, Mrs. Harold..New Harmony
Woods, Mrs. A. L.....Poseyville
Glackman, Jr., Mrs. J. C..Rockport
Kerrigan, Mrs. Wm. F....Rockport
Zwickel, Mrs. R. E.
Philadelphia, Pa.
Scales, Mrs. A. B...Pickstown, S.D.
Hart, Mrs. Paul.....St. Louis, Mo.

VIGO COUNTY

McIntosh, Mrs. Wilbert.....Riley
Carmichael, Mrs. C. S...Seeleyville

Terre Haute

Agee, Mrs. E. B.....1014 S. 22nd
Allen, Mrs. O. T.....32 S. 20th
Anderson, Mrs. W. C...380 S. 22nd
Ault, Mrs. Roy J.....1674A N. 7th
Baldridge, Mrs. E. R....1435 S. 6th
Baldridge, Mrs. W. O...2506 N. 9th
Blum, Mrs. L. L.....1101 S. 6th
Bohannon, Mrs. M. J...1400 N. 7th
Bopp, Mrs. H. W.....132 Barton
Bopp, Mrs. James.....2635 Wilson
Bradley, Mrs. S. C.....916 S. 25th
Brown, Mrs. Robt.....16 Monterey
Cajacob, Mrs. Melville..1000 S. 6th
Carpenter, Mrs. G. C....122 Barton
Combs, Mrs. C. N.....2516 N. 9th
Conklin, Mrs. J. O.....1006 S. 7th
Connelly, Mrs. J. J.....213 Barton
Curry, Mrs. C. A.....1402 S. 17th
Decker, Mrs. H. B.....R. R. 3
Donnelly, Mrs. J. E...2230 Garfield
Dorsey, Mrs. P. W.....1112 S. 25th
Dyer, Mrs. G. W.....2710 Wilson
Edmundson, Mrs. R. E.
2201 S. Center
Forsyth, Mrs. D. H.....714 S. 8th
Freed, Mrs. J. E., Jr..928 Monterey
Freed, Mrs. J. E.....2408 N. 10th
Fuqua, Mrs. H. B.....2303 N. 9th
Gilbert, Mrs. Ivan..2641 Crawford
Goodman, Mrs. H. T...328 Potomac
Gossom, Mrs. D. R.....3132 S. 7th
Haslem, Mrs. E. R.....205 Potomac
Haslem, Mrs. J. R.....2144 Poplar
Humphrey, Mrs. P. E....815 Maple
Kabel, Mrs. R. N.....3318 Oak
Krieble, Mrs. W. W..2100 S. Center
Kunkler, Mrs. W. C..1119 S. Center
La Bier, Mrs. C. R.....414 S. 22nd
La Bier, Mrs. Russell.21 McKinley
Lancet, Mrs. R. O.....426 S. 25th
Loewenstein, Mrs. W. L.
1421 S. 7th
Mahoney, Mrs. C. S..1430 S. Center
Malone, Mrs. L. A.....342 S. 22nd
Mattox, Mrs. D. A.....722 S. 5th
Mattox, Mrs. Ernest..Deming Wds.
McCarthy, Mrs. F. G.....926 S. 6th
McCormick, Mrs. W. C.
2156 College
McEwen, Mrs. J. W.
R. R. 5, Robinwood
Meyn, Mrs. W. P.....2101 S. 8th
Miller, Mrs. D. B.....903 S. 7th
Mitchell, Mrs. A. M.....333 S. 22nd
Nay, Mrs. E. O.....29 S. 20th
Oliphant, Mrs. R. W...123 Jackson
Pearce, Mrs. Roy V.....523 N. 7th
Pierce, Mrs. H. J....1514 S. Center
Reed, Mrs. R. C.....1912 S. Center
Richart, Mrs. J. V....Deming Wds.
Riggs, Mrs. Floyd.....137 S. 24th
Sayers, Mrs. F. E.
R. R. 5, Robinwood
Scherb, Mrs. B. E.....422 S. 25th
Schumaker, Mrs. R. A.
731 S. Center
Shaffer, Mrs. J. S.....2200 Third
Showalter, Mrs. J. R.
2638 8th Ave.
Siebenmorgen, Mrs. L...1200 S. 8th
Siebenmorgen, Mrs. Paul
1130 S. 8th
Siegman, Mrs. E. L....1000 S. 25th
Silverman, Mrs. N. M...1220 S. 8th
Speas, Mrs. R. O.....430 Willow
Spigler, Mrs. James....1436 S. 6th
Stoelting, Mrs. J. L.....1919 N. 7th
Sullivan, Mrs. J. M....2242 College
Topping, Mrs. M. C....152 Montrey
Van Arsdall, Mrs. C. R.
2229 Crawford
Vandivier, Mrs. H. R...225 Madison
Voges, Mrs. Ed C.....137 S. 20th
Weber, Mrs. Joseph...2121 N. 11th
Wiedemann, Mrs. F. E..1530 S. 6th
Yung, Mrs. J. R.....1115 S. 6th
Zaring, Mrs. E. T.
3325 Wabash, Apt. 3
Zwerner, Mrs. P. F.....712 Collett

Gerrish, Mrs. D. A..N. Terre Haute
Utterback, Mrs. A.
R. R. 2, W. Terre Haute
Luckett, Mrs. C. L.....Youngstown

WABASH COUNTY

Walker, Mrs. J. L.....LaFontaine
Seward, Mrs. Geo...N. Manchester
Kidd, Mrs. Gordon.....Roann

Wabash

Biggerstaff, Mrs. J. T.
677 N. Spring
Black, Mrs. E. K.....274 N. Miami
Dannacher, Mrs. Wm.
518 N. Wabash
LaSalle, Mrs. G. M....80 N. Miami
LaSalle, Mrs. R. M..442 N. Wabash
Pearson, Mrs. E. D....1380 Vernon
Pearson, Mrs. W. E.290 N. Wabash
Steffen, Mrs. A. J.....70 W. Hill
Stoops, Mrs. J. T.....259 N. Maple
Whisler, Mrs. F. M.....111 E. Hill
Wilson, Mrs. James...125 E. Main

WAYNE-UNION COUNTIES

Hill, Mrs. Paul....Cambridge City
Kenyon, Mrs. Emil.Cambridge City
Barton, Mrs. W. M.....Centerville
Hutchinson, Mrs. Robert
Fountain City
Lewis, Mrs. Frank.....Liberty

Richmond

Ake, Mrs. Loren.....1707 E. Main
Allen, Mrs. Robert.....21 S. 8th
Ballenger, Mrs. W. E...301 S. 22nd
Buche, Mrs. F. P.....106 S. 7th
Campbell, Mrs. Perry.....Cart Rd.
Coble, Mrs. Frank.....Liberty Pk.
Cook, Mrs. N. R.....305 N. 20th
Cox, Mrs. Leon.....148 S. 21st
Dingle, Mrs. Paul.....415 S. 15th
Ebbinghouse, Mrs. Tom.1324 Ridge
Ewbanks, Mrs. J. N.
Smith-Esteb Hosp.
Hadley, Mrs. Harvey...627 S. 14th
Hayes, Mrs. Geo....Keystone Apts.
Hagie, Mrs. F. 7.....164 S. 20th
Hill, Mrs. H. D.....17 S. 19th
Hoffman, Mrs. Curt....204 S. 21st

WAYNE-UNION COUNTIES

(Richmond—Continued)

Holland, Mrs. E. E...1907 E. Main
Hufnagel, Mrs. C. J.....436 S. 12th
Griffis, Mrs. V. C.....210 S. 23rd
Johnson, Mrs. Geo....338 SW. 15th
Johnson, Mrs. Paul.....200 S. 18th
Johnston, Mrs. M. F....105 N. 10th
Kime, Mrs. Charles....Liberty Pk.
Krueger, Mrs. F. W..Henley Rd., S.
Laird, Mrs. L. A....Rich. St. Hosp.
Lee, Mrs. G. W.....404 S. 15th
Ling, Mrs. John.....501 SW. 15th
Logan, Mrs. J. Z.....36 S. 15th
Mader, Mrs. John.....217 SW. 2nd
Meredith, Mrs. Elwood.200 S. 20th
Malcolm, Mrs. Russell..901 NW. B
Ross, Mrs. James.....3211 E. Main
Ross, Mrs. H. P.....220 S. 19th
Sage, Mrs. C. V.....48 S. 11th
Shields, Mrs. T. S.....47½ S. 11th
Snyder, Mrs. Morris....125 S. 20th
Stamper, Mrs. L. A.....420 S. 22nd
Stepleton, Mrs. John..1120 Central
Sweet, Mrs. Howard....20 S. 22nd
Vance, Mrs. William....200 S. 21st
Wanninger, Mrs. Horace
215 S. 15th
Warrick, Mrs. F. B.....22 DeBolt
Wertenberger, Mrs. Morris
115 S. 16th
Whallon, Mrs. Arthur...29 S. 10th
Wisener, Mrs. Guthrie..401 S. 18th

WELLS COUNTY

Bluffton

Annis, Mrs. H. B....225 W. Central
Aucreman, Mrs. C. J..314 W. South
Caylor, Mrs. C. E...114 S. Williams
Caylor, Mrs. H. D...411 W. Market
Caylor, Mrs. T. E.
River Rd., Box 264
Cook, Mrs. R. G.....R.R. 3, Box 44
DeRyke, Mrs. Gilbert.212 W. South
Dorrance, Mrs. T. O.218 W. Central
Eisaman, Mrs. J. L...427 W. Wiley
Johnston, Mrs. R. L..811 S. Morgan
King, Mrs. E. A.....320 S. Main
Lloyd, Mrs. J. T.....513 W. South
Nickel, Mrs. A. C....504 W. Cherry
Shively, Mrs. J. A..R.R. 3, Box 232
Smith, Mrs. H. B.....333 S. Wayne
Talbert, Mrs. P. C.....104 E. Wiley
Tirman, Mrs. W. S.....Villa North
Yoder, Mrs. R. P.....R. R. 3

WHITLEY COUNTY

Columbia City

Heritier, Mrs. C. J.
410 E. VanBuren
Langhor, Mrs. John...206 N. Main
Lehmberg, Mrs. Otto
118 E. VanBuren
Nolt, Mrs. E. V....209 S. Chauncey
Pence, Mrs. Benj...312 W. Jackson
Thompson, Mrs. Frank
531 E. VanBuren

Garber, Mrs. P. A...South Whitley
Huffman, Mrs. Park.South Whitley

MEMBERS-AT-LARGE

Hoeger, Mrs. H. R.....Brookville
Cummings, Mrs. D. J..Brownstown
Gillespie, Mrs. G. R....Brownstown
Shields, Mrs. J. E.....Brownstown
Tower, Mrs. T. K...Campbellsburg
Ashworth, Mrs. L. N.
2027 Indiana, Connersville
Cavitt, Mrs. Robert...Connersville
Dale, Mrs. M. H.....Connersville
Mountain, Mrs. F. B...Connersville
Dillman, Mrs. C. E.....Corydon
Stephens, Mrs. Lowell...Covington
Adair, Mrs. Wm. K.
208 Armstrong, Crothersville
Nolan, Mrs. R. E.....English
Leasure, Mrs. Kenneth.Etna Green
Davis, Mrs. John.....Flat Rock
Dickson, Mrs. Dale....Greensburg
Bonnell, Mrs. E. G.....Hillsboro
Berman, Mrs. J. K..1105 W. Kessler
Blvd., Indianapolis
Campbell, Mrs. John A.
5201 Grandview Dr., Indianapolis
Wayne, Mrs. E...7177 N. Meridian,
Indianapolis
Stouder, Mrs. A. E.....Kempton
Matthews, Mrs. Wm. C...Kentland
Rainey, Mrs. E. A.
912 N. Meridian, Lebanon
Lynch, Mrs. O. R.....Marengo
Linton, Mrs. C. E.....Medaryville
Carlyle, Mrs. I. E....Michigantown
Oswalt, Mrs. J. T.....Mitchell
Strickland, Mrs. W. B.....Mitchell
Shallenberger, Mrs. Henry..Modoc
Greist, Mrs. H. W.....Monticello
Stauffer, Mrs. George...Mooreland
Oliphant, Mrs. Frank..Mt. Vernon
Vogel, Mrs. J. L.....Mt. Vernon
Canaday, Mrs. C. E.
1411 Church St., New Castle
Hill, Mrs. Kenneth
1224 Audubon Rd., New Castle
Kennedy, Mrs. W. U.
701 S. 14th St., New Castle
Wiggins, Mrs. D. S.
219 S. 12th St., New Castle
Wiggins, Mrs. George
403 N. Main St., New Castle
Baker, Mrs. R. E.....Orleans
Row, Mrs. G. S.....Osgood
Woods, Mrs. A. L.....Poseyville
Allen, Mrs. F. K.....Salem
Gilliatt, Mrs. J. P.
204 S. High, Salem
Huckleberry, Mrs. Irvin.....Salem
Paynter, Mrs. L. W.....Salem
McClain, Mrs. Marvin L.
384 McClain, Scottsburg
Black, Mrs. J. N.....Seymour
Boss, Mrs. I.....Shelbyville
Whitcomb, Mrs. Roger..Shelbyville
Young, Mrs. E. M.
505 E. 5th, Sheridan
Reid, Mrs. R. W.
706 Division, Union City
Hopkins, Mrs. L. H.....Versailles
Whisler, Mrs. F. M.....Wabash
Coulston, Mrs. Sewell.....Waldron
Richer, Mrs. Orville.....Warsaw
Crain, Mrs. J. W.....Williamsport
Thompson, Mrs. Wm.
215 S. Market, Winamac
Sparks, Mrs. Helen B...Winchester
Moser, Mrs. E. B.....Windfall

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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

(Continued from Page 628)

action Indiana was taking on the intern and resident situation, was read. The executive secretary was directed to answer that the situation is being studied.

On motion of Drs. Clark and Ellison, the request of *The Union*, a labor paper, for authority to solicit subscriptions from members of the association by stating that the solicitation had been authorized by the committee, was disapproved.

Multiphasic screening program. Doctor Burney discussed the multiphasic screening program at the Herman Morgan Health Center, Indianapolis, which he said is an applied study of this new type of preventive medicine, after which a letter was read stating that the American Medical Association is collecting data on the subject in communities which now have multiphasic screening programs.

On motion of Drs. Weyerbacher and Kennedy the committee approved joining the Indianapolis Medical Society in the renting of a storage space in the basement of the Hume Mansur Building at an annual cost of $28.50 to the Indiana State Medical Association.

On motion of Drs. Clark and Ellison, the request of the Indiana Society for Crippled Children to use the association's mailing plates for mailing a reprint entitled, "Resources for the General Practitioner," was approved.

A statement of "General Policies and Principles of the Indiana State Board of Health," copies of which had been mailed previously to the members, was approved as submitted, on motion of Drs. Black and Ellison.

Doctor Booher reviewed the need for teaching girls employed in physicians' offices to do laboratory procedures, stating that they are to be known as office attendants and not laboratory technicians. On motion of Drs. Kennedy and Black, the report of the Committee to Study Training of Girls to Do Simple Laboratory Procedures, chairmanned by Doctor Booher, was approved as submitted to the Council on April 16, and the committee went on record as favoring adoption of this report by the Council at its meeting on July 16.

Doctor Burney discussed the recommendation that a Commission to Study Chronic Illness be created in Indiana, by appointment of the Governor. On motion of Drs. Clark and Kennedy, the committee voted in favor of the Indiana State Medical Association participating in this undertaking.

Mr. Maurice O. Hunt presented the problems of the county welfare departments in handling claims submitted for care of welfare recipients, after which, on motion of Drs. Black and Ellison, the Executive Committee voted to recommend to the county medical societies that they establish advisory committees to check claims for medical services and that a dentist and a pharmacist be asked to serve on the local medical advisory committee to assist in checking charges for dental services and pharmaceutical supplies.

After a resolution adopted by the Board of Trustees of the American Hospital Association in March, 1950, was read, a motion by Drs. Ellison and Kennedy, declaring that it is unethical and contrary to public interest for any lay corporation to practice medicine and to supply medical services for a professional fee which shall be so divided as to produce profit for a lay employer, either an individual or an institution, including hospitals and medical schools, was adopted.

Dr. Glen Ward Lee, chairman of the Committee on Veterans Affairs and Rehabilitation, reported on the meeting of the Emergency Medical Manpower Council of the American Medical Association which was held in Chicago on May 9. He said that each state is to set up a civilian medical defense program. The president of the Indiana State Medical Association designated the Committee on Veterans Affairs and Rehabilitation as the committee in Indiana to handle civilian emergency medical defense in case of an atomic bomb explosion.

Woman's Auxiliary

On motion of Drs. Clark and Kennedy, it was decided to meet with the officers and other leaders of the Woman's Auxiliary to the Indiana State Medical Association the latter part of July to discuss how activities of the Woman's Auxiliary may be integrated with the program of the Indiana State Medical Association. The executive secretary is to arrange for the meeting.

Future Medical Meetings

The field secretary was authorized to attend the A.M.A. session in San Francisco June 26 to 30, 1950, on motion of Drs. Ellison and Clark.

The executive secretary was directed to attend the American Public Health Association meeting in St. Louis, October 30 to November 3, 1950, and to participate in the Medical Care Section which will deal with compulsory health insurance.

The Journal

Total advertising in April issue	$2,268.07
Total advertising in May issue	2,236.27

On motion of Drs. Ellison and Clark, the committee voted to place the Health Information Foundation on the complimentary mailing list.

A list of the institutions advertising in THE JOURNAL is to be sent to the American Medical Association with a request that they be checked and the association informed as to whether they are ethical and eligible to purchase space in THE JOURNAL.

There being no further business, the Executive Committee adjourned to meet again at 6:00 p.m., Saturday, July 15, 1950, at the Athenaeum, Indianapolis.

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COMMITTEE ON PUBLICITY

May 5, 1950

Present: Marlow W. Manion, M.D., chairman; Homer G. Hamer, M.D.; James O. Ritchey, M.D.; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of June 12, 1950—"Summer Camp."
Week of June 19, 1950—"Undulant Fever."
Week of June 26, 1950—"Glaucoma."

The secretary read a letter addressed to George Lull, M.D., general manager of the A.M.A., setting forth the request of the committee for a more definite statement of policy regarding the radio series, "Americans, Speak Up." Doctor Lull's reply was read, and following the reading of this correspondence the committee, by consent, decided to take no further action in this matter.

A copy of an editorial appearing in *The Shelbyville News* was read.

May 19, 1950

Present: Marlow W. Manion, M.D., chairman; Homer G. Hamer, M.D.; James O. Ritchey, M.D.; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of July 3, 1950—"Function of Blood"
Week of July 10, 1950—"Night Driving"

The committee selected the radio series entitled "Fair and Cooler" to follow the present series.

The executive secretary informed the committee of a request he had received for an article for publication in *The Indianapolis Star*, on "Medicine in the Next 50 Years." The committee authorized the secretary to prepare such an article and authorized Doctor Manion to review the manuscript before forwarding it to the newspaper.

COUNCILOR DISTRICT MEETINGS

SECOND DISTRICT

The Knox County Medical Society was host to the Second District Medical Society for its annual meeting, held Thursday, May 25, at the Vincennes Country Club. Dr. R. M. Anderson, retiring president of the district society, had charge of the program. Thirty-five members of the society were present.

Five papers were given to make up the scientific program. Dr. James F. Reilly of Vincennes, in presenting his paper, discussed "Psychotherapy for the General Practitioner."

"Hematuria" was the subject for the paper given by Dr. Herbert M. Welch of Vincennes.

Dr. Nathaniel D. Ewing, Vincennes, gave an illustrated paper on "Skin Tumors."

"Some Things the General Practitioner Should Know About X-ray Therapy" was the title of the paper given by Dr. R. G. Moore of Vincennes, and the closing paper was by Dr. Ralph C. Smith, Vincennes, who discussed "Differential Diagnosis of Clinical Jaundice."

The meeting closed with a business session, at which time the following were elected to office: President, C. Philip Fox, M.D., Washington; Vice-President, James H. Crowder, M.D., Sullivan. J. S. Brown, M.D., Carlisle, was retained as Secretary. Sam Rotman, M.D., Jasonville, was elected Alternate Councilor.

James A. Waggener, field secretary, was a guest at the meeting.

THIRD DISTRICT

Members of the Third District Medical Society assembled at the Colgate Palmolive Peet Plant in Jeffersonville, on May 17 for their annual meeting. A tour of the plant was followed by a tea for the members of the Woman's Auxiliary at the home of Dr. and Mrs. Sam Adair in Jeffersonville. Scientific papers on industrial medicine were read by Drs. K. Armand Fischer and Winston U. Rutledge, both of Louisville. Dr. Elmer Henderson, president of the A.M.A., was the dinner speaker. Dr. Parvin Davis, of New Albany, was elected alternate delegate. New Albany was chosen as the site for the 1951 meeting.

FOURTH DISTRICT

The Fourth District Medical Society met in Greensburg on May 17, and was attended by approximately seventy physicians and guests. The scientific program consisted of the following: "Respiratory Infection," by J. O. Ritchey, M.D., of Indianapolis; "Venous Stasis of the Lower Extremities," by Edward J. Manwell, M.D., of Northampton, Massachusetts; "Cancer Detection and Treatment," by Charles Miller, M.D., of New York. Dr. Claude S. Black, president of the state association, spoke on problems facing the profession; Mr. R. E. Saylor, executive vice-president of Mutual Medical Insurance, Inc., gave a report on the company; and Mr. Russell Richardson, of Lebanon, spoke in the evening on "Socialism in England."

Officers elected for the coming year were: President, Dr. B. W. Thayer, of North Vernon; vice-president, Dr. Luther Beetem, of Madison; secretary-treasurer, Dr. D. W. Mathews, of North Vernon; and councilor, Dr. Charles Overpeck, of Greensburg.

(Continued on Page 698)

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(Continued from Page 696)

FIFTH DISTRICT

Dr. Basil M. Merrell of Rockville was elected president of the Fifth District Medical Society, at its annual meeting held May 17 in the Phoenix Country Club at Terre Haute. Dr. Gilbert D. Rhea of Greencastle was named vice-president, and Dr. Stuart R. Combs of Terre Haute was re-elected secretary-treasurer. Dr. V. Earle Wiseman of Greencastle was chosen as alternate councilor.

The scientific program in the afternoon was presented by three Indianapolis physicians, as follows:

"Psychiatry in General Practice"—Dr. Earl W. Mericle.

"Disorders of the Shoulder Joint"—Dr. Frank W. Teague.

"The Differential Diagnosis of Pneumonia"—Dr. I. J. Kwitny.

Ray E. Smith, executive secretary of the Indiana State Medical Association, spoke at the dinner in the evening. He addressed the Woman's Auxiliary of the district at its meeting in the afternoon.

Terre Haute was selected as the 1951 meeting place.

SIXTH DISTRICT

Members of the sixth district and their wives met Wednesday, May 24 at Greenfield for their annual meeting. The program began at 10:15 a.m., with a tour of the Eli Lilly Biological Laboratories, which had been arranged for the members and their wives. Following the tour the society adjourned to the Shelter House at Riley Park for lunch and the balance of their program, while the Auxiliary reconvened at the Riley Hotel for their lunch and program.

District president W. A. Thompson, M.D., of Liberty, welcomed the members of the district. This was followed by the reading of the minutes by Dr. R. W. Kuhn, Wilkinson, secretary, and the report of the Councilor by Dr. W. U. Kennedy of New Castle.

Three papers were given during the afternoon. Dr. Kenneth L. Craft, of Indianapolis, discussed "Allergic Conditions of the Upper Respiratory Tract."

Reporting on his recent trip abroad, Dr. Karl R. Ruddell, of Indianapolis, spoke on "Medical Conditions and Their Relation to Socialism in Europe."

Stating that this was the first time he had explained his new theory and demonstrated his new invention, Dr. Franklin E. Hagie, of Richmond, told of his method he now uses in "Open Reduction of Fractures of the Head of the Humerus with Plate and Lag Screws."

Guests at the meeting were Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Following a short business session, the members of the Auxiliary enjoyed a social program. Officers elected for the coming year by the Auxiliary are as follows: president, Mrs. Robert Johnson, Rushville; secretary, Mrs. Julia Davis, Shelbyville. Guests at the Auxiliary meeting included Mrs. L. E. Lybrook, Galveston, president, and Mrs. F. M. Fargher, Michigan City, president-elect of the Woman's Auxiliary to the Indiana State Medical Association.

The 1951 meeting is to be held during the month of May at Liberty. The dates will be announced later.

EIGHTH DISTRICT

A. C. Batters, M.D., Portland, was elected president of the Eighth Councilor District at its annual meeting, held Wednesday evening, May 17, at the Delaware Country Club in Muncie. D. E. Spahr, M.D., Portland, was elected secretary-treasurer, and T. R. Hayes, M.D., Muncie, was elected alternate councilor.

E. H. Clauser, M.D., councilor, stated in his report that the district had gained in membership during the year, and told of the programs being carried on by the counties in the district. "I have been impressed with the attitude of the county society officials," he stated. "Today there is a lack of indifference so commonplace a short time ago, and today it is evident that we are working together to make our profession strong."

James A. Waggener, field secretary, represented the headquarters office, and spoke on some of the activities of the association.

B. R. Kirklin, M.D., a former member of the eighth district, and who for the past twenty-five years has been chairman of the Section on Radiology at Mayo Clinic and Professor of Radiology of the Mayo Foundation, gave an illustrated lecture on "Diaphragmatic Hernia."

Muncie was tentatively selected as the 1951 meeting place.

NINTH DISTRICT

Dr. Harry E. Klepinger of Lafayette was elected alternate councilor and Lafayette was selected for the 1951 meeting at the Ninth Medical District Society meeting held at the Benton County Country Club at Fowler on June 1. The Tippecanoe County Medical Society will designate the district officers.

Nearly 150 persons attended the banquet in the evening and heard an entertaining and instructive talk by Thomas A. Hendricks of Chicago, secretary of the A.M.A. Council on Medical Service. Others who spoke were Dr. C. S. Black of Warren, president of the Indiana State Medical Association; Dr. F. S. Crockett of Lafayette, chairman of the A.M.A. Committee on Rural Health, and Ray E.

(Continued on Page 700)

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(Continued from Page 698)

Smith, executive secretary of I.S.M.A. Dr. V. L. Turley of Fowler presided.

Dr. Wemple Dodds of Crawfordsville, councilor, reported on activities of the state association at a meeting of delegates in the afternoon.

The following scientific papers were presented:

"Allergy of Upper Respiratory Tract" by Dr. Kenneth L. Craft of Indianapolis.

"Abnormal Vaginal Bleeding" by Dr. David A. Bickel of South Bend.

"Ear, Nose and Throat Problems" by Dr. Bert Ellis of Indianapolis.

Dr. Boyd A. Burkhardt of Tipton won the golf trophy with a low gross score of 80.

Forty-four were present at a meeting of the Woman's Auxiliary in the afternoon and heard talks by Mrs. D. E. Lybrook of Young America, state president; Mrs. Francis Fargher of Michigan City, state president-elect, and Mrs. Charles L. Richardson of Rochester, chairman of the state Program Committee. Cards were played. Mrs. V. L. Turley of Fowler is district president and Mrs. Ray W. Shanks of Noblesville is vice-president.

ELEVENTH DISTRICT

The Eleventh Councilor District Medical Association held its spring meeting at Marion on May 17, when the following officers were elected: president, L. D. Holliday, M.D., Fairmount; secretary-treasurer, C. R. Herd, M.D., Peru; alternate councilor, R. W. Lavengood, M.D., Marion. The newly-elected officers were instructed to prepare a suitable statement or plaque, to be presented to Dr. O. G. Brubaker, of North Manchester, for his twenty-three years of service as secretary-treasurer.

The scientific program consisted of papers on "Management of Arthritis and Related Conditions," by John Frost, M.D., of Indianapolis; "Jaundice," by Philip Thorek, M.D., of Chicago, and "Nerve Block for Anesthesia, Diagnosis and Therapy," by Donald Hale, M.D., Cleveland.

Members of the Woman's Auxiliary were entertained at a luncheon and style show in the afternoon. The speaker of the evening for both groups was Mrs. Leslie Stevens, wife of Admiral Leslie Stevens, United States Attaché in Moscow. Her subject was: "Life in the Worker's Paradise Behind the Iron Curtain."

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LOCAL SOCIETY REPORTS

Clinton County Medical Society members met at the Clinton County Hospital, in Frankfort, on May 2. Eighteen members were present to hear Dr. T. A. Dykhuizen, of Frankfort, speak on "Nephritis and Nephrosis."

Hendricks County Medical Society members met at Avon on May 2, when Dr. Donald Wood, of Indianapolis, spoke on "Hormones as Related to General Practice." Eight members were present.

Orange County Medical Society members met at West Baden Springs Hotel, in West Baden on June 6. This was a business meeting, and eight members and two guests were present.

Putnam County Medical Society members held a meeting on April 14 at the Putnam County Hospital in Greencastle. Eighteen members were present. The guest speaker was Dr. J. O. Ritchey, of Indianapolis, whose subject was "Atypical Pneumonia."

Whitley County Medical Society members held a meeting in Columbia City on February 14, when Dr. Richard Estlick, of Fort Wayne, spoke on "Diseases of the Ear and Sound Perception." Seven members were present.

On March 14 another meeting was held, when Dr. Russell Havens, of Fort Wayne, spoke on "Types of Anesthesia." Eight members were present at this meeting.

At the April 11 meeting thirteen members were present to hear a representative of Blue Cross—Blue Shield discuss their coverage.

Another meeting was held on May 9, when Dr. J. L. Langohr, of Columbia City, spoke on "Common Sense Treatment of Burns." Eleven members attended this meeting.

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Deaths

George Harrison Davis, M.D., of Union City, died on June 1, after a long illness. He was seventy-five years of age. He was a graduate of Indiana University School of Medicine in 1909, and began the practice of medicine in Spartanburg. After two years he moved to Union City, where he had practiced until his retirement in 1945. Doctor Davis was an honorary member of the Randolph County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Dudley F. Davis, M.D., of New Albany, died on June 6, at the age of eighty-two. He was a graduate of the University of Louisville School of Medicine in 1892, and began the practice of medicine in Crandall. From there he moved to New Albany, where he had practiced for forty-seven years. He was an honorary member of the Floyd County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

James R. Lewis, M.D., of Indianapolis, died on May 13, after a brief illness. He was seventy-two years old. Doctor Lewis graduated from the Medical College of Indiana, in Indianapolis, in 1901, and had practiced in Indianapolis for fifty years. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

Mr. H. Herschel Leiter, president of DePuy Manufacturing Company, of Warsaw, Indiana, died on May 9 at Nashville, Tennessee. Mr. Leiter was best known for advancement in splints, not only for his own inventions, but for improvements developed through cooperation with leading orthopedic men, to make available the most advanced techniques in fracture therapy.

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THE ACUTE ABDOMEN*

PHILIP THOREK, M.D.†

CHICAGO

THE subject of the acute abdomen will always present an interesting challenge to the practitioner and surgeon alike. I have examined charts from the surgical services at the Cook County Hospital for a period of ten years, the purpose being to determine which diseases are most frequently mistaken in the acute abdomen. To my surprise I did not find fifty or seventy-five conditions which confuse us, but rather six outstanding ones that we mistake most frequently. These six conditions are:

1. Acute Appendicitis.
2. Acute Cholecystitis.
3. Perforated Peptic Ulcer.
4. Acute Hemorrhagic Pancreatitis.
5. Renal Colics.
6. Coronary Disease.

There is a seventh disease which deserves special consideration, namely, salpingitis. Acute or chronic salpingeal pathology is frequently associated with a perihepatitis which produces pain in the right upper quadrant (pseudo-gallbladder pain). Because of this, gallbladder explorations and other surgical procedures have been done in cases of salpingitis, resulting in danger to the patient and embarrassment to the surgeon.

To make a diagnosis one must have a simple and workable plan in mind. Our plan consists of the headings, namely, history, present symptom complex, physical examination and laboratory data. This routine has served us well and we utilize it daily.

ACUTE APPENDICITIS

The more one sees of acute appendicitis, the more one respects the condition. The statement "only an appendix" is indeed a dangerous one. This condition is most frequently found in individuals under the age of forty and is somewhat more common in males. It will be recalled that gallbladder conditions appear most frequently after the age of forty. The story the patient relates is usually quite stereotyped. To put it in his language: "Something I ate gave me a belly-ache." This is his way of describing acute epigastric distress. When he gets this "belly-ache" he often attempts to obtain relief with either a cathartic or an enema. Within the first twenty-four hours his "belly-ache" becomes a soreness low on the right side. His acute epigastric distress has become localized to the right lower quadrant. The "two-question test" is both useful and time-saving. Question Number 1: "Where was your pain when it started?"; to this interrogation the patient points to his entire abdomen. Question Number 2: "Where does it hurt you now?"; he then points to the right lower quadrant, usually McBurney's point. This simple method of having the patient demonstrate diffuse pain which localizes to the right lower quadrant will diagnose the vast majority of cases of acute appendicitis.

Nausea and vomiting have been impressed upon us as being associated with appendicitis. This is

* Presented at the 1950 Scientific Session of the Indiana Academy of General Practice, Indianapolis, April 19, 1950.

† From the Departments of Surgery of the University of Illinois, Cook County Graduate School of Medicine, Cook County Hospital, American and Alexian Brothers' Hospitals.

the exception and not the rule. Anorexia, or loss of appetite, is more constant and more important than either nausea or vomiting. Anorexia, nausea and vomiting are three degrees of one symptom; anorexia is the mildest form and is associated with mild distention of the appendix; nausea, the middle degree, is due to moderate distention; and vomiting, the maximum degree, is found in greatly distended appendices. The most common symptom in acute appendicitis is anorexia, and if the patient states that his appetite is not altered we doubt the diagnosis of an acute appendix. Two complaints which are extremely rare in acute appendicitis are diarrhea and chills. These are probably found in less than 1 percent of the cases. Constipation is the rule.

Fever is not an early finding in acute appendicitis; in fact, if present it is suggestive of peritoneal soiling. It is true that cases of acute appendicitis may have a fever of 102° or 103°, but these are no longer cases of appendicitis; they are cases of far advanced peritonitis. Children prove the exception to this rule. If appendices could be operated upon when the temperature is below 99° the mortality would be very low.

Acute appendicitis does *not* give right rectus rigidity. Although the reverse is taught in many schools and textbooks, this point should be clarified. It is impossible for an individual to contract his right rectus muscle without contracting the left; therefore, when pressure is made upon an inflamed area, both rectus muscles contract. When only one rectus is rigid it suggests an underlying mass, such as a tumor or abscess. When both recti contract to pressure it should be considered "muscular defense" rather than right or left rectus rigidity. The importance of this bears emphasis when we realize that diagnosis, treatment and prognosis may depend upon the presence of right rectus rigidity or simple muscular defense.

The iliopsoas and obturator signs are not signs which diagnose acute appendicitis, but rather locate an acute appendix. Probably a misconception has arisen because these signs are usually discussed under the heading of acute appendicitis; they may, however, be produced in other diseases. The right iliopsoas sign is elicited by placing the patient on his left side and hyperextending the right leg. If positive, pain is produced over the iliopsoas fascia which will be manifested in the region of the right lower quadrant. In the presence of a history of acute appendicitis this would signify that the inflamed appendix is overlying the iliopsoas fascia and is retrocecal. A positive obturator sign will locate an inflamed pelvic appendix. It is conducted in the following way: with the patient on his back the thigh is flexed upon the abdomen and the leg upon the thigh; the leg is then abducted. This causes internal rotation of the thigh and stretches the obturator internus muscle. If this produces pain it is diagnostic of a fascitis involving the obturator fascia, which could be caused by an inflamed tube, appendix, ovarian cyst, etc. If the patient elicits a history of acute appendicitis with a positive obturator sign, we conclude that the appendix is low-lying and in the pelvis. Rovsing's sign is also helpful. It is elicited by pressing over the left cecum, the colonic gas which has been pushed to the right will produce pain over the cecal region; this is quite diagnostic of acute appendicitis.

Routine bidigital examinations are done; at times an acute appendix or appendiceal mass may be felt. Late and neglected appendices may produce a pelvic abscess which points rectally or vaginally, and this examination reveals the proper site and time for incision and drainage.

The laboratory data usually consist of a white blood count and a urinalysis. More important than the white blood count or urinalysis is a differential blood count; this is easy to do and is more accurate. If the "poly" count is high, we assume that an acute infectious process is present; a high "poly" count in the presence of a low white count means a poor prognosis. The urinalysis is usually negative but may be misleading; a few red cells in the urine are not pathognomonic of renal pathology. Negative urines have been recorded where a renal stone completely blocks the ureter so that no blood or pus can pass into the bladder.

ACUTE CHOLECYSTITIS

The dictum that certain types of people are predisposed to certain types of diseases seems to be correct. The gallbladder type is described as fair, fat and forty, usually being a female in the latter third or fourth decade and somewhat obese. There is always an exception to the rule; hence, the most fulminating hydrops of the gallbladder on our service was seen in a young, thin boy of sixteen. The age of forty is related to a previous history of pregnancy, and this is theoretically explained in the following way: the average female has her children in the second decade of life and while pregnant she develops a physiologic hypercholesterolemia. Some of this cholesterol deposits on the mucous membrane of the gallbladder, forms polypi which break off and become the nuclei for stones. It may take from ten to twenty years for gallstones to attain any appreciable size, so that by the time she reaches her fourth decade the stone is large enough to obstruct or irritate. Nulliparous women can also have gallstones or gallbladder disease, but this, too, is the exception and not the rule.

The history of recurrent attacks of abdominal pain in a middle aged female, so severe that the physician must administer a sedative, is an acute gallbladder until proved otherwise. Acute appendicitis does not require morphine; renal colics will be differentiated presently, and coronary occlusion is rare in the female. One of the most unusual lesions noted in the female is a perforated peptic

ulcer. The gallbladder patient also presents a previous history of "selective dyspepsia." By this we mean that there are certain specific foods that she cannot tolerate. There are four primary offenders to these foods; they are fried and fatty foods, raw apples, cucumbers and cabbage. The patient does not use the term "dyspepsia," but describes this distress as the two "B's": namely, bloating and belching. To summarize and describe the gallbladder patient one may use an alliteration and state that she is the patient with the seven "F's": she is the Fair, Fat, Fertile, Flatulent, Flabby, Female of Forty.

The complaint is one of pain, and it is important to determine the type of pain which is present. A constant pain is due to edema, but colicky pain is caused by obstruction. This is one of the factors which indicate whether the case should be treated conservatively or surgically. It is unwise to treat an obstructed lesion conservatively since these are cases which result in early gangrene and perforation. Morphine should not be used in gallbladder disease because it is a smooth muscle contractor, and since the gallbladder is a smooth muscle organ one should not administer a medicament which would stimulate its activity. By increasing muscle tonus, morphine may actually aggravate or provoke gallbladder pain and colic. One should not state, however, that the drug must never be used in gallbladder disease, since it still has its place, namely, to prevent shock. These patients are treated first with nitrite therapy. One breaks an amyl nitrite bead and lets the patient inhale the vapors; 1/100th grain of nitroglycerin is placed under the tongue, and 3 grains of sodium amytal or any other barbiturate is given by mouth. If this gives no relief we administer a hypodermic which consists of 100 mg. of demerol and 1/100th of a grain of nitroglycerin. Should these measures fail, antispasmodic therapy with such drugs as papaverine or aminophylline is tried. Morphine is used only after all other measures have failed.

Gallbladder pain is usually located under the right costal margin, but may be referred to the stomach since these two organs originate from the same embryologic segment. The stomach responds to this stimulus in one of these types of gastric spasms: (1) pylorospasm, (2) midgastric spasm and (3) cardiospasm. If a pylorospasm is produced the gallbladder condition might be confused with peptic ulcer. If midgastric spasm results, a stomach carcinoma may be erroneously diagnosed; and if associated with cardiospasm, the pain appears on the left (pseudocoronary pain) and coronary disease may incorrectly project itself into the diagnostic picture.

Referred pain should not be confused with radiation of pain. By radiation we mean that gallbladder pain, located under the right costal margin, may radiate along the path of the seventh intercostal nerve to the inferior angle of the right scapula, or the interscapular region. Gallbladder pain, therefore, cannot radiate to the right shoulder. Shoulder pain is an entirely different mechanism which involves the phrenic nerve and is indicative of peritonitis. When a gallbladder patient has true shoulder pain a diagnosis of gangrenous or ruptured gallbladder with biliary peritonitis should be made.

Temperature, pulse and respirations are included under the heading of physical examination. The patient with an acute gallbladder has an early high fever, hence a temperature of 102° is not unusual within the first twelve to twenty-four hours of acute cholecystitis. The early fever is explained by the absence of a submucosa. Since this tough resisting layer is lacking, there is greater chance for early contamination and absorption in the peritoneal cavity. The patient has a pulse which is increased according to the temperature; therefore, for every degree of rise in fever there will be approximately a ten beat increase in pulse rate. Respirations are slightly increased because breathing is painful. This is due to the fact that the inflamed gallbladder rubs against the sensitive parietal peritoneum; because of this, acute gallbladder disease may be confused with pneumonia or pleurisy.

Although pain, a symptom, may be referred anywhere along its nervous path, tenderness, a physical finding, remains at the site of pathology. This is an excellent diagnostic rule having few if any exceptions. The tenderness of gallbladder disease will be located in the region of the right costal margin. If it is most marked on a level with the umbilicus, it may be difficult to determine whether the condition is an inflamed, low-lying gallbladder or an acute, high-lying retrocecal appendix. Two ways aid in the differentiation of these two conditions. First, we recall that the normal abdomen reveals a tympanitic note to percussion in all four quadrants. If the tenderness opposite the umbilicus is due to an inflamed gallbladder, we assume that the organ is unusually large or that a ptotic liver with an inflamed gallbladder at its free border is present. This would cause an obliteration of the normal tympany in the right upper quadrant and in its place the percussion note would be one of dullness or flatness. If the patient presents tenderness on the level with the umbilicus and retains normal tympany in the right upper quadrant, this would point to a high-lying retrocecal appendix. Another method of differentiating the gallbladder and appendix is by means of Ligat's test. This test locates areas of hyperesthesia over an inflamed organ. If the tenderness is due to gallbladder disease an area of hyperesthesia (elicited by picking up the skin and letting it drop) is present from the umbilicus upward to the right costal margin. If the tenderness is due to an acute appendix, the area of hyperesthesia will be found from the umbilicus down to Poupart's ligament.

A rectal examination is done as a routine in every physical examination. More important than the rectal or vaginal examination is a so-called bidigital, which is conducted by placing the index finger in the vagina and the middle finger in the rectum with the perineum in between. This will immediately orient the examiner and adnexal pathology will be revealed.

A flat x-ray film should be taken in every acute abdominal condition. One may determine whether a calcified gallbladder or visible stones are present. It also gives an indication as to whether or not the liver is enlarged or ptotic. Routine laboratory tests are done.

PERFORATED PEPTIC ULCER

This condition is rare in females. Usually a previous history of peptic ulcer or hemorrhage can be obtained, but the onset may be with perforation.

The patient states that he was seized with a sudden pain, usually after eating; this was so severe that it doubled him up. The classical picture of perforated peptic ulcer with board-like rigidity and a shock-like syndrome is too well known to bear repetition. Two signs which should be sought for in every case, however, are: (1) the findings with auscultation, and (2) the presence of a pneumoperitoneum. Auscultation reveals an absolutely silent abdomen when an ulcer perforates, leaks and soils the peritoneal cavity. This is not new, since the late J. B. Murphy stressed the importance of this finding many decades ago. When intestinal sounds are present, the diagnosis of perforated peptic ulcer is remote. There are exceptions, and one of these will be discussed presently under the subject of forme fruste ulcer. The next sign which helps clinch the diagnosis is the demonstration of a spontaneous pneumoperitoneum. Normally a magenblase or stomach air bubble is present. When an ulcer perforates, this air bubble escapes into the general peritoneal cavity, and can be demonstrated either by percussion or with the fluoroscope; the latter is by far the more accurate. The patient is placed on his left side so that the free air bubble may gravitate upward between the liver and the right hemidiaphragm. By so doing, the liver is displaced downward and is separated from the diaphragm. Normally the liver hugs the diaphragm and no air space is visible between them. If this air is of an appreciable amount, normal liver dullness is obliterated and in its place a tympanitic note is produced by percussion. The sign is easy to demonstrate, quite pathognomonic of perforated peptic ulcer, and present in about 70 percent of all cases.

The forme fruste ulcer deserves special mention. The term refers to a pinpoint perforation in the stomach or duodenum which is immediately sealed over by muscular contraction or by the overlying liver. Therefore, the spillage is minimal and the amount of peritoneal soiling is small. Such patients may experience a sudden sharp pain in the epigastrium, but the typical physical findings are lacking. This patient may be able to straighten up and walk about. Abdominal sounds are usually present and the air bubble may remain intragastric, having had no chance to leave the small perforation. These patients, therefore, present a misleading picture and have been misdiagnosed. However, with the ingestion of their next meal they usually reperforate and then present the typical findings.

The temperature, pulse and respirations will depend upon whether or not shock is present. Most perforated peptic ulcers present a shocklike picture which varies in its intensity. The shock associated with perforated ulcers responds rapidly to therapy. Within a few hours the classical picture of peritonitis develops, with the associated increase in temperature, pulse and respiratory rate.

The contents from a perforated ulcer may pass downward along the so-called "paracolic gutter of Moynihan," pool around the appendix and produce exquisite tenderness at McBurney's point. The diagnostician must then be on his guard, since such a history would suggest an epigastric distress with localization to the right lower quadrant which could be confused with an acute appendix. Upon exploratory operation, free fluid will be found in the peritoneal cavity with all signs of a peritonitis, and a red and injected appendix seen and removed. These patients usually die if the leaking ulcer is overlooked. This catastrophe can be avoided if, before closing the abdomen, the appendix is opened and the mucous membrane examined. Since acute appendicitis starts in the lumen of the appendix and travels outward, a normal appearing mucous membrane would suggest looking elsewhere for the cause of the peritonitis.

Laboratory data includes the flat x-ray film which has been discussed under the subject of spontaneous pneumoperitoneum. Routine blood count and urinalysis are done. Some of these patients might have bled, and although perforated ulcers are known not to produce massive hemorrhage, signs of a secondary anemia may be present.

ACUTE HEMORRHAGIC PANCREATITIS

It is important to recall that this disease may appear in one of two forms: either acute edematous pancreatitis or hemorrhagic pancreatitis. The former presents a mild clinical picture, but the latter, which is associated with fat necrosis and occasionally a hemorrhagic peritonitis, produces a fulminating one. The acute edematous form usually improves rapidly without therapy within 48 hours, but hemorrhagic pancreatitis gets progressively worse and often requires surgical intervention. It is the hemorrhagic type, therefore, which is important to identify and treat promptly.

Although the etiology of pancreatitis is un-

known, there seems to be a mechanical factor which is associated with Spasm, Stones, Swelling and Stasis. Recent work seems to emphasize the relationship between acute pancreatitis and acute cholecystitis. This seems to be due to a common factor which is an obstruction distal to the junction of the pancreatic and common bile ducts converting them into a "common channel." An actual reflux of pancreatic juice into the gallbladder during an attack of acute pancreatitis has been shown. The patient who develops acute pancreatitis is usually of the same type that develops gallbladder disease, therefore the condition is more common in females, rarely occurring before the age of forty, and is seen in stout people. The ratio of colored to white is 1 to 50. The attack usually follows the ingestion of a heavy meal. The pain is dramatic, sudden and excruciating; it is felt in the epigastrium, and radiates into one or both loins. In this way pancreatic pain radiation resembles an inverted fan. When the patient sits up or lies on his abdomen, the pain is relieved, and is aggravated when he is on his back. Hence, in most pancreatic conditions, be they tumors or inflammations, the patient is usually found lying on his abdomen or in a sitting position. Reflex vomiting or retching almost always occurs; emesis which is truly reflex in nature is never feculent.

Physical examination reveals a patient who is usually in shock, with cold and clammy extremities, subnormal temperature, and a rapid, thready pulse. Local epigastric tenderness is almost always present and is associated with a type of muscular defense which is localized to the same area. The rigidity is not truly board-like in nature, and the tenderness is most marked midway between the umbilicus and the xiphoid. An occasional finding is ecchymosis in one or both loins, or at times around the umbilicus. This is due to extravasated blood which finds its way around the retroperitoneal space and presents itself as greenish yellow or purplish discolorations. This finding, however, takes two or three days to appear. Mild jaundice is present in about half of the cases; this is explained by the fact that the common duct is pressed upon by a swollen head of the pancreas. Abdominal auscultation usually reveals a quiet but not silent abdomen.

Laboratory findings may be helpful in the diagnosis. An increase of serum amylase is specific in the acute phase, although a normal reading does not rule out acute pancreatitis. Polowe has emphasized the importance of determining the blood amylase activity in terms of cuprous oxide precipitation. He has shown that moderate to marked blood amylase activity is almost always associated with diseases of the pancreas, and normal or decreased blood amylase almost always excludes pancreatitis. Hypocalcemia is usually present and the level found is usually below nine. A flat x-ray film of the abdomen may reveal a separation of the upper and lower limbs of the duodenum brought about by an edema of the head of the pancreas. This latter finding is unusual.

RENAL COLICS

Stones are not the only substance which produce renal colics, since the same syndrome may be produced by a small blood clot, inspissated pus, uratic debris, or a kinking of the ureteropelvic junction in a ptotic kidney.

The condition is more common in males, and the patient may reveal a history of previous attacks, a hereditary influence, a story of gout, or parathyroid pathology.

The patient complains of a sudden pain which starts in the lumbar region and radiates to the testicle, vulva or the inner aspect of the thigh. With this pain he becomes extremely restless and thrashes about. A patient who is experiencing a colic is restless and moves about, but one who has a peritonitis lies perfectly quiet and resents being moved. Vomiting is a common symptom, as is a frequency of urination. During the act of micturition the pain may be altered.

Physical examination rarely reveals any elevation in temperature, but extremely characteristic of the condition is a bradycardia. It has often been stated that when a patient with an acute abdomen has "a clean tongue and a slow pulse" he has a renal colic until proved otherwise. Tenderness is most marked in the region of the twelfth rib of the involved side, and to elicit this finding it is unnecessary and cruel to utilize any type of "punch" test. The tenderness is so exquisite that mild percussion will demonstrate it. We prefer to use the term "Murphy tap" to "Murphy punch." A zone of hyperesthesia is usually found posteriorly at the level of and slightly below the twelfth rib. If this area is anesthetized with novocain, the hyperesthesia and pain disappear.

A flat x-ray film may reveal a stone if such is present, but this is not reliable since nonopaque substances may also produce kidney colic. An intravenous pyelogram can be made without disturbing the patient, and if necessary the films can be taken at the bedside with the aid of a stationary grid. The significant finding for a diagnosis of a stone in the ureter is the anuria which may be present on the affected side; the opposite side shows normal excretion. The kidney on the affected side usually appears increased in density since the dye in these tubules is more concentrated. This finding is sufficient for diagnosis of nonopaque stones in the ureter. A catheterized specimen of urine usually reveals pus, blood and albumin. The presence or absence of pus and blood in the urine is not pathognomonic since a stone may completely block the ureter and result in a normal urine. On the other hand, an inflamed appendix may be attached to the ureter, kidney or bladder, resulting in a secondary ureteritis, nephritis or cystitis with an associated hematuria.

In such instances the laboratory report may actually be misleading.

CORONARY DISEASE

Although this belongs to the realm of the internist, the general practitioner as well as the surgeon must be on his guard to avoid the fatal error of confusing an acute coronary disease with an acute abdominal condition.

Men are most susceptible to this condition, and it is usually found in those past the age of forty. A previous history of dyspnea or pain in the chest during exertion or excitement may be elicited. The attack is sudden, with severe pain in the chest which radiates out the left arm towards the abdomen or both shoulders. There is a sense of impending death with severe fright which usually supersedes the complaint of pain. The radiation may also be toward the epigastrium, so that the examiner's attention is directed to the abdomen rather than the chest. A usual complaint during such an attack is one of "indigestion." Although the pain of acute coronary disease may occur in the abdomen, it does not become localized; hence, no area of local abdominal tenderness is ever found. Marked abdominal distention may be present in coronary pathology, but muscle defense or rectus rigidity are lacking. In abdominal catastrophes the patient lies perfectly quiet, but the coronary patient resembles the colic, in that he is restless and tosses about. The acute cardiac patient presents veins in the neck which are distended and full, in contrast to the patient with the surgical abdomen who may appear pale and bloodless. Signs of impaired circulation are usually present, such as dyspnea, orthopnea and cyanosis. Auscultation will usually reveal rales in both bases due to pulmonary congestion. Cardiac enlargement, feeble heart sounds and occasionally a pericardial friction rub may be found. During auscultation of the abdomen, normal intestinal sounds will be heard which are absent or diminished in cases of peritonitis.

Positive electrocardiographic findings are pathognomonic, but one is not always fortunate enough to have an electrocardiogram handy. A leukocytosis may be present some hours after the disease takes place, and the urine is usually negative unless there is associated renal pathology.

We realize that many other conditions at times require differentiation in the acute abdomen, among them strangulated hernia, regional ileitis, mesenteric lymphadenitis, mesenteric thrombosis, ruptured ectopic pregnancy, ruptured graafian follicle, ileocecal tuberculosis, vasitis, torsion of the omentum, volvulus, intussusception, ad infinitum. However, when one misses one of these unusual conditions he does not feel quite as responsible or guilty as he would having missed one of the aforementioned "Big Six."

Members of the State Association will again have the opportunity of returning to school for a day at the 101st Session of the Indiana State Medical Association at French Lick September 25, 1950. The instructional Course Committee has arranged a curriculum of 30 classes, and so arranged the schedule that a total of five of these classes may be selected and attended in consecutive order. Each class will last a total of 55 minutes, during which time a brief presentation will be made of the current knowledge in a particular field of interest, together with sufficient time for some discussion of the subject on the part of the "students." The reservations for these classes should be sent in promptly in order that you may secure the particular selection of courses desired.

THE DIFFERENTIAL DIAGNOSIS OF JAUNDICE

B. D. Rosenak, M.D.

INDIANAPOLIS

THE principal problem in the differential diagnosis of jaundice is the distinction between those patients who may require surgical treatment and those who should be treated medically. This separation of medical and surgical jaundice implies a difference in the mechanism whereby jaundice has developed. It is therefore essential to understand something of the physiologic disturbances which lead to elevation of the bilirubin in the blood and to clinical jaundice.

The site of the pathological process differs in the various types of jaundice and it is this which constitutes the principal distinguishing feature between them. The pathologic process may lie before, within or beyond the liver, producing prehepatic or hemolytic jaundice, intrahepatic or hepatocellular jaundice, and posthepatic or obstructive jaundice, as the case may be.

HEMOLYTIC JAUNDICE

Jaundice which is caused by prehepatic factors is called retention jaundice and is due to abnormal production of bilirubin by excessively rapid destruction of red cells. The classic example of this form of jaundice is congenital hemolytic icterus. Other conditions which may cause similar jaundice are massive hemorrhages, hemolytic infections or intoxications, or transfusions of incompatible blood. The recognition of this group of diseases usually presents no serious diagnostic difficulty. One must be familiar with the history so that the pertinent factors suggestive of familial icterus are not overlooked and the presence of toxic or infectious processes may be adequately evaluated. If hemolytic jaundice is suspected there are laboratory procedures which are of definite aid in confirming or excluding this type of jaundice. It is in these cases that the differential van den Bergh test is of assistance. When the bilirubin is of the prehepatic type it remains united to a protein molecule from which it must be separated by the action of an additional reagent such as alcohol before color is produced with Ehrlich's diazo reagent. This type of bilirubin is therefore called indirectly reacting bilirubin and will predominate in cases of hemolytic jaundice. For example, in a patient with hemolytic jaundice 70 to 90 percent of the total bilirubin may be of this type. However, in cases complicated by gallstones or prolonged jaundice with impaired hepatic function there may be a greater proportion of direct bilirubin. It is therefore necessary to interpret this test in the light of the clinical condition.

The anemia which develops during the crisis of this disease may be severe and the red cells are found to be of a peculiar type, being smaller and thicker than normal, and in the smear they appear to have lost their central pallor. These so-called spherocytes occur characteristically in this disease. These cells are known to rupture with ease, therefore another laboratory procedure which may be of value in the diagnosis of hemolytic jaundice is the red cell fragility test which is usually positive during the crises of the hemolytic anemias. Normal responses are usually anticipated from tests for liver disease such as the flocculation, sugar tolerance, and dye retention tests. Here again one must be certain that complications such as gallstones or secondary hepatic insufficiency are not present. Sufficient evidence is usually obtained from the history and physical examination in cases of this type to arouse the suspicion of the physician. Confirmation can be provided in most instances after a reasonable period of observation and study.

INTRAHEPATIC JAUNDICE VERSUS OBSTRUCTIVE JAUNDICE

The differentiation between medical or intrahepatic jaundice and surgical or posthepatic obstructive jaundice remains one of the most baffling problems in clinical medicine. The physician is too often in the unfortunate position of delaying operative intervention because of uncertainty as to whether there is interference to the flow of bile or of advising exploratory operation to ascertain this point in a patient who is suffering from hepatic disease and is therefore a poor surgical risk.

INTRAHEPATIC JAUNDICE

Medical or intrahepatic jaundice is usually due to some form of hepatitis or cirrhosis. Chemical toxic effects on the liver must also be considered but are not common enough to cause much confusion in differential diagnosis. The term hepatitis is at once a specific and a general one. To most physicians it now applies primarily to the epidemic virus hepatitis which was identified during World War II. A more specific designation, homologous serum jaundice, is applied to that form of the disease which occurs after administration of blood or plasma. Variants of these diseases extend from a mild, self-limited illness with complete recovery to rapidly fatal necrosis of the liver. The recognition of this disease depends upon familiarity with its clinical features and can usually be corroborated by suitable laboratory tests. Every jaundiced patient must be carefully questioned

in regard to previous transfusions of blood or plasma. It is even possible that a history of intravenous injections would be a pertinent feature of the history since it is known that minute quantities of serum retained in improperly sterilized syringes may transmit the disease. Contacts with patients who have been jaundiced might also be regarded as suggestive of virus hepatitis.

Patients of any age may suffer from hepatitis. However, those in the older age groups are more apt to have obstructive jaundice. In the classical case of virus hepatitis the jaundice is preceded by several days of anorexia, nausea and some abdominal discomfort. This is followed by dark urine and acholic stools and then noticeable icterus of the skin. It must be remembered that there is often a phase of intrahepatic obstruction in these cases during which the stools are acholic. This feature of the clinical picture would suggest obstructive jaundice but no harm is done by watching such a patient for a few days, observing the color of the urine and feces for evidences of improvement. The degree of jaundice may increase for a considerable time, often running into weeks, and may reach very high levels. However, one of the most critical features of the nonfatal cases of hepatitis is in the onset of recrudescence of jaundice. This feature is watched for intently by physician, patient and family, since it usually signifies the beginning of recovery.

Enlargement of the liver is common in these cases. It is usually slight or moderate in degree, but the liver is always smooth and is usually tender. This physical sign is not of great differential diagnostic value since hepatomegaly occurs in other forms of jaundice. The spleen may or may not be palpable but this also is of no great importance in diagnosis.

Laboratory aids are of distinct value in confirming the diagnosis of hepatitis in most cases. It is usually unnecessary to perform a very large number of such tests, but it is necessary to repeat the selected tests at rather frequent intervals. It is essential first to obtain some test of the degree of jaundice. The quantitative serum bilirubin determination is preferred. The differential van den Bergh test is of no value since both hepatitis and obstructive jaundice produce direct reacting bilirubin. The icterus index test serves well for this purpose if its shortcomings are kept in mind. These tests should be repeated at intervals of three to seven days. Sometimes daily tests are desirable. In the pre-icteric stage of the disease bilirubinuria may be discovered by use of one of the sensitive barium chloride tests. Tests which reflect some disturbance in the serum globulins, such as the cephalin cholesterol flocculation, thymol turbidity and the colloidal red test will be found to be positive in most diseases of the hepatic cells. These tests are, of course, not specific, but long clinical trial has established their value in this type of hepatic disease. They may remain positive for several months after an attack of hepatitis. In many cases the serum albumin will be found to be low. This is not as consistent as in cirrhosis but the test should be performed in every case of liver disease. Tests based on sugar clearance, such as the galactose tolerance test, are usually positive in hepatitis. The hippuric acid synthesis is also impaired in most cases of acute hepatitis. The excretion of urobilinogen in the urine and feces will be found to be elevated during some phases of the disease. The prothrombin time is often prolonged and the response to vitamin K therapy will be poor in severe cases.

The physician must choose the tests he will use on the basis of his own experience and facilities. All or any of the above tests, if positive early in the course of a case of jaundice, signifies that cellular damage is present and justifies the assumption that this may be the primary pathology.

Cirrhosis of the liver should be recognized by its clinical features in most cases. Although cirrhosis is a prominent cause of medical or intrahepatic jaundice, this sign is by no means universal in cirrhosis. Familiarity with the early clinical features of this disease will enable the physician to make the diagnosis during a phase of the disease which favors a good therapeutic result. A history of chronic alcoholism, especially if associated with dietary deficiency, arouses a strong suspicion of cirrhosis and is often sufficient to justify thorough study. We now have proof that chronic or repeated episodes of hepatitis may also lead to cirrhosis of the liver. These features of the history must not be neglected. Anorexia and nausea may occur early in this disease. The principal physical finding is hepatomegaly, which may be very marked. The liver is usually smooth and may be tender. The spleen may also be enlarged. The physician should be alert for such signs as typical spider nevi over the chest, neck and shoulders, and palmar erythema. Deviations of secondary sex characteristics, such as absence of pectoral hair and gynecomastia, may be found in male patients. The classical picture of the emaciated patient, with ascites, edema and jaundice, is readily recognized and the occurrence of hemorrhage from esophageal varices in such a patient is indicative of advanced disease. Much can be done for the patient with early cirrhosis of the liver and prompt diagnosis must be our goal.

Laboratory aids are of distinct value even in very early cases. The serum bilirubin may be moderately elevated or may be normal. It will usually be up and down during the course of the disease. However, this test is not of great diagnostic importance. The flocculation tests fall into the same class. They are often positive, but not uniformly so.

The retention of bromsulphthalein in the blood has been found to be a very reliable test in this disease. Marked degrees of retention are noted

in even the mildest cases and may persist for several years. This test is considered to be of the greatest value in the diagnosis of cirrhosis of the liver.

Disturbances of the serum proteins are found almost universally in cirrhosis. Extreme depression of the serum albumin level may be noted. This variation is a valuable confirmatory test for severe hepatic disease; it cannot be regarded as specific in cirrhosis, but is certainly a uniform finding in this disease, whereas it may vary greatly in other liver diseases. It will also be found that the serum globulins are usually increased. This is not an apparent increase due to reversal of the A/G ratio, but a positive elevation which has been found to be due to increased gamma globulin. The subject of the variations of blood proteins in hepatic disease is not fully understood, but there is ample evidence of significant abnormalities which may be utilized for diagnostic purposes.

We have found moderate elevations of the serum alkaline phosphatase to be extremely common in our cirrhotic patients. The levels are usually lower than those in biliary obstruction, but these elevations now seem to be an almost characteristic feature of the laboratory findings. Levels up to 20 Bodansky units are very common. Many other tests may be found to be abnormal in cirrhosis, but those mentioned above have proven adequate in our experience for confirmation of the diagnosis and for following the progress of the disease.

OBSTRUCTIVE JAUNDICE

It is again necessary, in beginning a discussion of the diagnosis of obstructive jaundice, to emphasize the great need for recognition of the clinical features which may point to interference to the flow of bile. There may be instances in which it is possible for the physician to make the diagnosis of biliary obstruction with great certainty on his first visit to the sick room. In other cases extreme caution, prolonged observation and much laboratory work may be required.

The age of the patient is often of considerable importance in arousing the suspicion of obstructive jaundice. The pathological states, gallstones and cancer, which commonly cause obstruction, occur much more often in the middle-aged and elderly than in young adults or children. This does not imply that the doctor should immediately exclude other causes of jaundice in such patients. A history of recurrent attacks of right upper quadrant pain or even of a single attack suggestive of biliary colic arouses the suspicion of gallstones and suggests obstruction as the cause of jaundice. If the patient should reveal in addition a history of recurrent attacks of pain and jaundice, complicated by chills and fever, it becomes highly probable that intermittent obstruction due to common duct stone is present.

The character of the jaundice is often regarded as having some differential diagnostic significance. This is an uncertain clue and is apt to lead to error. The jaundice of obstructive etiology is greenish in hue, but this is also true in intrahepatic jaundice, whereas the hemolytic type is golden yellow in color. The color of the jaundice, therefore, does not aid in differentiating the two most easily confused types. Pruritus is also sometimes thought to have some value as a diagnostic clue, but is likewise undependable since itching may occur in both intrahepatic and obstructive cases.

One of the most reliable clinical signs of biliary obstruction is the absence of bile pigment from the stools. It must be emphasized that completely acholic stools are white or grey in color, without a trace of brown or yellow. If the stools are persistently acholic one may be quite sure that obstruction exists, and if they resume a yellow or brown color it may be presumed that obstruction, if present, is intermittent. The occurrence of transient acholic stools in hepatitis has been discussed.

Progressive deepening of jaundice is indicative of biliary obstruction and though this may be estimated at the bedside, if the patient is observed in good natural light, it is far better to ascertain the degree of jaundice by laboratory means.

The presence of a palpable gallbladder is always suggestive of obstruction of the common bile duct and is an indication, according to Courvoisier's law, that the obstruction is due to neoplasm. In typical cases it is not difficult to be certain of the nature of this abdominal mass. The gallbladder is globular, smooth and usually freely movable below the liver margin. The liver itself is often enlarged, particularly if obstruction is of long standing. This suggests another clinical feature of obstructive jaundice; namely, the long duration of jaundice in some of these patients. There is often surprisingly little effect on their general well-being. Another clinical hint may be obtained from the presence of symptoms or positive evidence of carcinoma of other parts of the gastrointestinal tract which suggests the possibility of obstructive jaundice due to metastatic glands.

Laboratory tests which may be of assistance in proving the diagnosis of interference to the flow of bile include repeated determinations of the serum bilirubin, quantitative determination of urobilinogen, serum alkaline phosphatase and serum cholesterol. The course of the jaundice in the presence of complete obstruction due to stone or to neoplasm is progressively upward. This must be followed by repeated determinations of the serum bilirubin or icterus index.

In the complete absence of a flow of bile into

the gastrointestinal tract there will be an absence of production of urobilinogen. This may be determined by qualitative or quantitative tests for urobilinogen in the urine or feces. The qualitative test for urinary urobilinogen is very easily done and may show persistent absence of urobilinogen in the presence of high degrees of obstruction. If quantitative tests are available they will show very low or absent excretion of urobilinogen, indicating marked interference to the bile flow. It should be emphasized that repetition of these tests at frequent intervals is extremely important. Very high levels of serum alkaline phosphatase occur characteristically in obstructive jaundice. The total serum cholesterol may also be elevated in obstructive jaundice. This usually occurs in prolonged cases and may not be of early diagnostic value. Other tests of liver function such as the flocculation tests, dye retention tests, hippuric acid synthesis and sugar tolerance tests are expected to be within the normal limits in early cases of obstructive jaundice. It must be remembered that with persistent jaundice cellular damage develops and those tests which indicate some disturbance of the hepatic cells themselves may eventually become positive. The time interval required for this complication has not been definitely established and probably varies greatly.

CONCLUSIONS

The doctor must keep certain statistical data in mind regarding the incidence of the various types of jaundice. To this knowledge he must add the influence of the patient's age on the incidence of each type of jaundice. He must next be thoroughly familiar with the clinical features of the diseases which may cause jaundice and must consider carefully into which category a given case fits. Then he is ready, by judicious use of laboratory procedures, to test his hypothesis. This may require prolonged study, repeated tests, and x-ray examinations. Despite all of this, certain cases may defy his diagnostic skill, and rarely exploratory operation is unavoidable. It should be constantly remembered that the patient with liver disease tolerates sedation, anesthesia and surgical shock poorly.

HYPERTENSION

W. Donald Close, M.D.

INDIANAPOLIS

An elevated blood pressure is a physical finding—not a disease. As such, it may be temporary or permanent and may or may not be the result of serious disease. Page[1] has described 52 conditions that may have hypertension as a part. Of these, 50 were classified according to etiology. The remaining two, however, account for about 95 percent of the true hypertensives and are essential and malignant hypertension. These two may be one and the same disease. This discussion is presented in an effort to develop a practical, usable program for the care of a patient with essential hypertension. The term essential is not a good one because it implies that all of these cases in this category have a common if unknown etiology. This is probably not true, but they are only grouped together because of the common factor of unknown etiology. While this is a heterogenous group, we are forced to consider them as a unit for the present. It is most likely, however, that when they are all finally classified, most of the group will be found to be the result of one etiological factor.

In order that a clear understanding of this problem can be obtained we should first consider what we know about the group—essential hypertension. It is a common disease of unknown etiology, manifested by an elevated diastolic blood pressure, running a variable course with an unknown prognosis, associated with vascular change; treatment is expectant and unsatisfactory; and death is due to cardiac, cerebral or renal complications secondary to the vascular changes.

A consideration of each of these points helps to clarify our opinion on the proper program for the hypertensive patient. The first point—it is a common disease—needs no proof. The true proof rests in the number of patients that are seen by every doctor each day. This is true, but just how common is it. We have no really reliable statistics on this because most of the series have been poorly classified and it is not definitely stated what has been included. There have been insufficient series in which a true base line blood pressure has been established. In consequence, we are not sure that only those patients who have a fixed hypertension of the diastolic type of unknown cause have been included. For instance, a series of cases which rely upon those rejected for military service would of necessity contain

a limited number of observations on each person and these under very unusual circumstances. Statistics from the actuarial studies of insurance companies are subject to the same criticisms in that they are the result of very superficial study on a selected group, especially in regard to age and sex. As near as can be determined by review of combined statistics, the incidence is placed at 50 percent of the population past 40 years of age, and 15 percent of the population between 20 and 40 years. Much has been written concerning the sex differences and series can be found that would suggest that there is a marked difference. The most recent studies, however, have shown that this difference is more apparent than real and that there probably is no significant difference.

The next point to be considered is that of unknown etiology. Almost every organ, system or physiological state has been accused of being the cause, but none have been proved nor have they been of much help in the understanding of the disease in man. Probably the psychomotor, endocrine, hereditary and humoral factors all play a part in the development of the final picture. Which is primary and which is secondary and what percentage each contributes to the clinical picture in each patient must await further knowledge.

Now the statement manifested by a diastolic hypertension—this needs emphasis because many patients are laboring under the impression that they have hypertensive disease when they have as the only manifestation an elevated systolic pressure. The absence of diastolic elevation is probably proof that this condition is not present unless some other factors are operating to produce a fall in diastolic pressure. Elevation of the diastolic pressure is the most common manifestation of the disease and yet it is a variable finding in regard to degree. There are three factors that control the blood pressure. They are cardiac output, blood viscosity, and peripheral resistance. In the case of a true essential hypertension, only the latter is disturbed, which accounts for the diastolic elevation and serves to differentiate the condition.

The statement that it runs a variable course and prognosis explains the reason why we have been unable to evaluate the different forms of therapy. The reason that we know so little about the true "life history" of essential hypertension is because of the lack of reliable series as mentioned under the discussion of incidence. The series of Keith, Waggner and Baxter[2] has long been accepted as a basic series of the course of untreated cases. This is not a good group to use as a basis for comparison because 66 percent of their cases were in their class four which was the most severe group. They found only 9 percent of their patients alive five to nine years later. Every practicing physician knows that this cannot be the true survival rate because of their personal experience with patients. In the past few years several series, particularly those of Perera[3] and Ranges,[4] have been published. While these are not applicable to statistical study they do serve to emphasize that this condition often runs a long benign course and is not the dread disease that some think. Goldring and Chasis[5] emphasized that some patients who have manifestations of a severe disease, including marked retinal changes, undergo spontaneous improvement with retrogression of the eyeground changes.

Since we do not know the over-all course and prognosis of the disease, prognostication and therapy evaluation in a given patient are very difficult or impossible. Nevertheless, the following general impressions will help some in this regard.

1. The blood pressure tends to rise with the duration of the disease, but this rate of rise is very variable.

2. If the diastolic pressure is about 100 for eight years and there is only minimal heart or kidney involvement, the life expectancy may be only three to four years less than normal. This is especially true if the patient is over fifty years of age.

3. Cerebral vascular complications tend to increase the longer the duration of the hypertension. It must be remembered, too, that the longer the duration of the hypertension the older the patient and the other causes of vascular accidents operate more frequently with advancing age.

4. The absolute level of blood pressure is a poor guide to prognosis. This is so because the degree of vascular change and absolute level show no reliable correlation and it is the vascular changes that control the course of the disease.

5. The so-called blood pressure symptoms—headache, fatigue, cardiac palpitation, nervousness and insomnia—have been found to be no more common in the hypertensive than in the nonhypertensive. The presence or absence of these symptoms offers no guide to the severity of the disease or to prognosis, nor can they be correlated to the level of the blood pressure.

6. A rapidly rising blood pressure, encephalopathy, papilledema, vertigo, and convulsions all give a poor prognosis and suggest that the patient is developing the accelerated (malignant) form of the disease or has developed marked vascular changes. They carry a poor prognosis. As stated above, however, some of these will show a marked natural regression.

The statement that essential hypertension is associated with vascular changes while a simple and true statement tends to bring forward the fact that we really do not know much about this phase of the problem. It is believed that at least early in the course of the disease there is a large

vasospastic factor which may or may not be reversible. This spastic element is known to operate at varying degrees from time to time in the same patient, as well as from patient to patient. Later the incidence of both arteriolar and arterial sclerosis is more common in the hypertensive patient. We need to know, and do not know, if these changes are caused by the elevation of blood pressure or if the vascular changes cause the hypertension, or if they are each a separate manifestation of a third, more fundamental cause.

Treatment is expectant. Expectant treatment is that in which the doctor helps to control the symptoms of the disease while nature controls the course. As emphasized above, the variable and unknown course of the untreated disease makes evaluation of therapy most difficult. It is fair to state, however, that no therapeutic agent, be it psychotherapy, drugs, diet or surgery, has been proved definitely to alter the course of the disease. Until such an agent has been found treatment must remain expectant.

Death, when it is the result of essential hypertension, is caused by changes in the heart, brain, and kidneys. These changes are secondary to the vascular abnormalities found in the disease. The clinical picture of each is the usual one of insufficiency of the organ. Cardiac complications account for about 65 percent and of these two-thirds are congestive heart failure and one-third myocardial infarction. Cerebral vascular complications account for about 25 percent and the kidneys the remaining 10 percent.

Having determined that the patient has essential hypertension, which is so common and concerning which we know so little, what should we know about the case before deciding upon therapy? In other words, what is a practical program for this individual patient?

The first question that must be answered is, what is the status of the blood vessels in the heart, brain, and kidneys? The commonly used procedures which are available to all are sufficient to answer this question in all but the very exceptional patient. The investigation should start with the detailed history and a complete physical examination, paying special attention to the heart, eyegrounds, and neurological system. Laboratory studies, including blood count and urinalysis, including the specific gravity to determine the kidneys' concentration power, should be done. If the urine's specific gravity is over 1.024 and no sugar or appreciable amount of albumin is present, the concentrating power can be considered satisfactory. An x-ray examination of the heart, aorta, and the lung fields, along with an electrocardiogram and determination of the NPN or blood urea nitrogen, would complete the average study. This would furnish sufficient data for the clinical evaluation of the average patient's heart, brain and kidneys.

The next problem is to determine the rate of development of the disease. If this is not apparent from the history, and it usually is not, the patient's general condition, not just his blood pressure, must be observed over a period of a few months to a year.

The next question to answer is, are there any other diseases present? Essential hypertension, being a chronic condition and one found most often in the older age group, frequently co-exists with other diseases. The program of therapy for the hypertension must be altered at times because of these coexisting conditions.

Having determined the general condition of the patient, the plan of therapy must be determined. Now the question is, what therapeutic agents are available and what are the indications for their use? The aim of therapy in this condition, as it is in any incurable condition, is to keep the patient as comfortable and happy as possible while he follows as nearly a normal life as he can. The first need of a hypertensive patient is to have the services of a composed and friendly physician who understands him and his problems. The family doctor in his own community is best suited for this purpose. It is only the occasional patient who requires the services of a specialist or unusual therapy.

The keystone of therapy for the hypertensive patient is psychotherapy. There is seldom any need for the formal type of psychotherapeutic interview or analysis. They need reassurance and education of the true characteristics of their disease with emphasis on the frequency of the condition and its compatability with a long and useful life. It should be emphasized that the condition is not severe enough to warrant extensive therapy and constant observation. The blood pressure level should be minimized and in the asymptomatic cases should be taken only occasionally along with other examinations. The patient should be encouraged to lead as normal a life as possible and to avoid only the excesses. The aim of psychotherapy is to keep the patient feeling as well as possible and cure should not be expected. The program should consist of education, encouragement, and the correction of any recognized definite psychic trauma that may be present. Fear should never be used and the patient's life should be altered or reorganized as little as possible. The hypertensive disease or the level of the blood pressure should not be used to explain each and every symptom or complaint that the patient may have. This type of psychotherapy is not superficial therapy but is fundamental and is the bedrock of all other types of therapy.

The number of drugs that have been and are being used in the care of the hypertensive patient is prodigious. Many of these have given great promise, only later to be proved of little value. One group of drugs, the "sedatives," has persisted and

is outstanding in value. They are to be used in small doses during the day, if necessary, as an adjunct to psychotherapy to help keep the patient's "psychic lid on." Used at night to insure a good night's rest they are also of great help in enabling the patient to start the next day at his best physical and emotional level. As mentioned above, there are many agents that have been and are being used in an effort to reduce the blood pressure itself. The need or the advisability for this reduction has not been determined. It does, however, seem that this would be a good thing if it could be accomplished. Be that as it may, there is no drug available which has been effective in producing a sustained drop in blood pressure to any significant degree without undesirable side effects. The search for the proper drug continues. The veratrum derivatives and the sympathetic blocking agents are at present receiving a great deal of attention. Some usable product may be developed but only time will tell. There are, no doubt, many good reasons for using some of the many preparations available in the management of the patient with hypertension, but it should be remembered that they for the most part are used only as an adjunct to psychotherapy in the management of the patient and do not alter the course of the disease.

Diet has been for many years a definite part of the therapeutic routine. They have been many and varied. The diet which has stood the test of time is the reduction one in the overweight patient. Weight reduction should always be a part of the practical program for the obese hypertensive. In the past few years the rice diet and the low sodium diet have been advocated. There seems no doubt that certain hypertensive patients receive great benefit from the use of these diets. There is no known way at the present to select these patients who are the so-called sodium reactors. To be effective the diet must be extremely low in sodium, about 200 mgm. A diet that contains this small amount of sodium is a potentially dangerous one. Frequent studies of the body's electrolytes, cardiac and kidney status, must be made to avoid trouble. The diet is particularly dangerous in those patients who have renal impairment. These diets when used should be persisted in, if possible, from two to three months before it is determined that they will be of no value, because an occasional patient will require this much time before any appreciable results can be demonstrated. There is no value in just a moderate reduction of salt or sodium in the treatment of hypertension without heart failure.

Sympathetic surgery has been used as a therapeutic agent for many years. Even though this is so and intensive studies have been made by many surgeons using various operations, the indications and value of these procedures are not yet clear. It is just as true of surgery as with the other agents that there is no proof that it definitely alters the natural course of hypertensive disease.

There are many varied opinions as to which type of patient should have a sympathectomy, and it is difficult for the practicing physician to have a clear and practical opinion. Of all the various criteria the following, which closely follow that of Fishberg,[6] seem to be the most practical. When these criteria are used, it will be found that surgery should be advised in about 4 percent of hypertensive patients.

1. It is not indicated in the asymptomatic patient with a diastolic blood pressure under 130 mm. of mercury.
2. It is indicated in the truly symptomatic patient with a diastolic blood pressure under 130 mm. if the symptoms do not respond to other therapy.
3. It is indicated in cases with a suddenly rapidly rising blood pressure especially when there are associated retinal changes, hypertensive headaches, cerebral vascular accidents, or encephalopathy, and congestive heart failure which is readily controlled by the usual methods.
4. It is contraindicated in the presence of arterial sclerosis, renal failure or cardiac failure which cannot be controlled.

SUMMARY

A practical program for the management of the patient with essential hypertension which is based on our knowledge of the disease would be as follows. The patient should receive as little therapy as possible and still keep him comfortable and safe. The basic therapeutic procedure is psychotherapy consisting of education and encouragement by his own physician with the addition of whatever drugs may seem to be of value. Failure of this line of therapy would constitute an indication for the trial of the rice or low sodium diets if there is no kidney complication. Surgery should be advised for those patients who do not present the contraindications and who continue to have true hypertensive symptoms in spite of other therapy and for those who are developing the accelerated form of the disease.

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USE AND ABUSE OF THE SKIN TEST IN THE DIAGNOSIS OF CHRONIC BRUCELLOSIS

Dan L. Urschel, M.D.

MENTONE

CHRONIC brucellosis is a disease entity too frequently diagnosed by a few physicians and not diagnosed often enough by the majority of doctors.

After several years spent in clinical research in brucellosis, and in talking with many country physicians who are seeing the disease, the above statement seems entirely applicable. The average general practitioner in this part of the country, dealing wholly or in part with a rural practice, finds himself baffled by the contrast between that which he reads in the medical literature and that which he sees in his office. This confusion is principally to be laid on the doorstep of those who have been writing regarding the findings in this puzzling condition. We have argued about the significance of a low titer agglutination, we have discussed the opsonic index, which few laboratories are prepared to do, and we say that the blood cultures are seldom positive and therefore of little use. We describe numerous and sundry symptom complexes which appear to add up to no single clinical entity. Then, to completely and finally send the physician back to diagnoses of neurasthenia, psychoneurosis, chronic nervous exhaustion, et cetera, we tell him that the skin test doesn't mean much, even if it is positive, because anyone who has ever had the disease, even in a subclinical form, may have such a positive test.

It is not my purpose to go into the problem of diagnosis in great detail in this paper. This has been adequately covered in previous publications, by myself and others.[1, 2, 3, 4] Chronic brucellosis is such an indefinite symptom complex that all other sources of illness must be definitely ruled out. This cannot be emphasized too strongly. Brucellosis is, in its chronic form, a disease often diagnosed by exclusion. In brief, it may be said that it is a disease entity manifested principally by tiredness, often by low grade evening fever, and characterized by a variety of chronic and recurrent aches and pains. Diagnosed as any of a number of conditions, responding poorly to treatment, the patient becomes increasingly neurasthenic. He wanders hopefully from doctor to doctor. He may be fortunate enough to recover spontaneously, but if this does not happen, his only hope is correct diagnosis and treatment.

Confronted with this poor, miserable patient, who gives an adequate history of possible or probable exposure to Brucella organisms, who presents an essentially negative physical examination, and whose laboratory tests, including the agglutination, are noncontributory, what do we have available that will enable us to confirm our tentative diagnosis of brucellosis? It is at this point, and only at this point, that our much-maligned aid, the intradermal test, should be used.

METHOD AND MATERIAL IN SKIN TESTING

At one time Brucella vaccine, a suspension of killed organisms, was universally used in the skin test in this disease. However, it was found that many patients showed a marked adverse local reaction with necrosis. This tissue destruction can usually be prevented by the use of purified preparations, such as brucellergen, which is a nucleoprotein derivative of Brucella organisms. Other purified extracts have also been used, their common advantage being the lessened degree of local tissue damage. However, any product may produce a violent response in a sensitive individual, and this point cannot be too strongly emphasized. If one is dealing with a veterinary surgeon, with a laboratory worker who has been exposed to massive Brucella infection, or with a farmer whose cows have recently been infected with Bang's disease, the test solution should always be diluted. Several years ago I did simultaneous comparative tests of vaccine and brucellergen in skin testing suspected brucellosis cases.[5] Brucellergen produced far less local reaction, and appears to be the best agent available to us at the present time. As prepared commercially, it comes in a dilution of 1-12,000. This standard solution should usually be diluted 1 to 10, 1 to 100, or even 1 to 1,000, in making the preliminary test.

The test is performed by injecting 0.1 cc. of the test solution intradermally. It must be emphasized that this should be done carefully, with a short bevel needle, of 25 or 26 gauge, and that a visible and definite vesicle be produced by the injected fluid.

The test is best read at 48 hours. By this time the hyperemia resulting from the injection will have subsided and almost all positive reactors will be demonstrated. There has been some discussion as to what constitutes a significant reaction, but palpable induration of any size is certainly positive. In my opinion, erythema alone is not significant unless it is more than two centimeters in diameter.

It is to be noted here that an occasional patient will show a delayed skin reaction, and a positive

response may appear several days later. The patient should always be cautioned to return if the skin response becomes positive after the 48 hour examination.

SIGNIFICANCE OF THE SKIN TEST

For practical purposes, a negative skin test rules out *chronic* brucellosis. Cases have been reported with a positive agglutination or positive blood culture who had a negative skin response. However, this is extremely unlikely in the chronic phase of the disease, and for those of us engaged in country practice, it may be stated without contradiction that you must have a positive skin response before you can make a diagnosis of chronic brucellosis. A positive skin test, however, does not *make* the diagnosis. It merely *confirms* the impression which has been reached from a careful history and physical survey as detailed above. This point will be emphasized in the following discussion.

ABUSES OF THE SKIN TEST

The first abuse is as regards the selection and dosage of testing material. We must always be wary of the hypersensitive patient and use only such testing substance as will be unlikely to produce severe local reaction. We have discussed this under "Method and Material" above, and need not go into further detail.

The second abuse lies in performing the skin test before obtaining blood for agglutination. It has been repeatedly shown that intradermal testing will produce positive agglutinations, so we must always get the blood samples before doing the skin test. The agglutination response, though often negative in the chronic patient, is still of sufficient importance to be obtained in every person suspected of having brucellosis. If you wish to do a skin test and take blood for agglutinations on the same day, it will be very wise to take enough blood to leave a small specimen in the refrigerator in case the one you have mailed to the laboratory is broken in transit. You may find yourself without an agglutination report, and the patient having been skin tested, further diagnostic tests on his blood are valueless.

A brief word regarding the significance of the positive agglutination is pertinent here. In diagnosing chronic brucellosis, *any* positive titer may be significant. You have heard many arguments as to what constitutes a diagnostic titer in the acute disease, but these arguments are not valid in connection with the chronic form. It is my opinion that in the absence of previous skin tests or vaccine therapy, any positive agglutination must make one strongly suspect the presence of clinical brucellosis.

A third, and major, abuse of the skin test is a negative one, the failure to use this valuable diagnostic aid in patients with chronic disease. Far too often is the patient told that he definitely does not have brucellosis, merely because his blood agglutination is negative. This is inexcusable. Far too many reports have been published to show the low percentage of positive agglutinations in the chronic phase of the disease to allow us to use that test alone as a criterion of illness. Only a few patients with hypertension have albuminuria, yet it would be just as logical to rule out hypertension by doing only a urinalysis, as it is to rule out chronic brucellosis by doing only an agglutination.

The major abuse of the test, and one that has made it subject to skepticism, and even ridicule, has been overemphasis. There have been those who have considered a positive skin test, alone, sufficient to make the diagnosis of chronic brucellosis. In the present state of our knowledge it would appear just as logical to tell every patient with a positive tuberculin that he had active tuberculosis. In an urban population, the percentage of positive reactors is low, and in such circumstances the patient who presents a positive response should always be regarded with suspicion, but those of us who practice in rural areas must have a more skeptical attitude. We should skin test only those patients who give a significant history of chronic illness, who have had adequate exposure, or presumptive exposure to Brucella organisms, and who have had other causes for their complaints adequately ruled out. Under such circumstances, a positive response can then be regarded as a true diagnostic measure.

SUMMARY AND CONCLUSIONS

The skin test has been misused in the following ways:

1. Local tissue necrosis has been produced by vaccines inadequately diluted.
2. The skin test has been performed before proper blood tests had been obtained, thus creating positive agglutinations of no significance.
3. The test has been misused by lack of use. Many patients have been told they could not have chronic brucellosis on the basis of agglutinations alone.
4. Too much emphasis has been placed on reaction size. Induration is always significant.
5. The test has sometimes been needlessly overemphasized. It has been used as the sole agent of diagnosis of chronic brucellosis, without regard to a careful history and elimination of other diseases causing similar symptoms.

In summary the skin test for brucellosis often constitutes our sole confirmatory diagnostic aid in the chronic form of the disease. If it is considered in this light and not used as a haphazard selector of people with Brucella sensitivity, it will

be an invaluable aid to us. We know that it is a truly specific response, that there are no significant cross reactions with other organisms, and that a positive test indicates present or past contact with Brucella organisms.

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PENICILLIN IN ACUTE RHEUMATIC FEVER
CASE REPORTS

WALTER S. FISHER, M.D.

COLUMBUS

THE MEDICAL reports would indicate that penicillin has been universally ineffective as a treatment of rheumatic fever.[1-2] So far as I can learn very little recent work has been done in this field. There is plenty of evidence that penicillin and other chemotherapeutic agents are quite effective as a prophylaxis.[3-4-5] I have been treating acute rheumatic fever since January 1947 with penicillin alone. My experience leads me to believe that this antibiotic is effective if given very early in such cases and in adequate doses. Cases that have been ill for more than three weeks have not responded very well to this treatment.

To date nineteen early cases have been treated by the following method:

Patients are given one-half to one million units of penicillin in 500 cc. normal salt solution intravenously. This is given slowly through a twenty-two gauge needle. Two hundred to two hundred fifty thousand units of penicillin is given intramuscularly every three hours until the temperature reaches normal and the acute joint symptoms have subsided. Then the dose is reduced to one hundred thousand units every three hours for the remainder of the treatment. These smaller doses are continued for about a week. The number of doses of penicillin required to bring about a complete recovery is in direct proportion to the length of time the patient has been ill before the treatment is started.

The slowly absorbing penicillin preparations are not so effective in the acute stages of the disease. The more recent preparations of penicillin, containing both the rapidly absorbable and slowly absorbable penicillin, are suitable. The latter-mentioned preparations are quite suitable in the treatment of children.

The cases chosen to receive penicillin, as outlined above, are those who have the following histories and physical and laboratory findings. The history shows previous undisputed attacks of rheumatic fever or the history of a sore throat one to two weeks before. The physical findings are fever, definite leukocytosis, increased sedimentation rate, migrating polyarthritis with pain, redness, heat, swelling and soreness of the joints.

A few representative early cases are herein reported in more or less detail, as well as one subacute and one chronic case of rheumatic fever, for comparison.

CASE I

R. C., white male, age 14 years, entered the hospital January 23, 1949, with the diagnosis of acute appendicitis. His illness began January 22, 1949, with pain and vomiting. On admission to the hospital his temperature was 100° F. The W. B. C. was 19,850 with 70 segs, 6 stabs, and 22 lymphs. The urine was normal. The serology was negative. Undulant fever test was negative. Surgical consultation was called and the diagnosis of acute appendicitis was not substantiated.

The following day, January 24, 1949, he began to have pain in the right shoulder. The temperature rose to 102.4° F. The next day, January 25, 1949, he had pain, redness, swelling and soreness in the right knee. The abdominal symptoms were subsiding rapidly. There appeared at this time a rather rough systolic murmer at the apex. On January 26, 1949, he had the same joint symptoms appearing in the left ankle and the left knee. The sedimentation rate was now 28 mm.

At this point a diagnosis of acute rheumatic fever was made and I was asked to direct the treatment. The electrocardiogram showed a PR interval of the 22/100 of a second with definite elevation of the take-off of the ST interval in all leads with upright T waves. This is compatible with acute rheumatic pericarditis and myocarditis.

The patient was started on penicillin January 26, 1949, in the usual manner. The highest temperature recorded the following day was 100.7. This was the last day any temperature above 98.6 was recorded. There was marked clinical improvement. The joint symptoms had practically subsided in 48 hours. At the time of his discharge from the hospital February 1, 1949, there were no joint symptoms. The cardiac murmur was disappearing. He had received penicillin from January 26, 1949, to February 1, 1949.

After his discharge from the hospital his physician kept him in bed three more weeks because of his heart murmur. At the end of that time he had no evidence of any disease remaining. He was allowed to go back to school. The boy has remained well ever since.

CASE II

J. A., white female, age three years, became ill one afternoon with fever, general malaise, and soreness of the left ankle. The following morning the child was unimproved and a physician was called. She had by this time pain, soreness, redness, heat and swelling of both ankles.

The past history showed that the child had always been well except for some asthma associated with colds. The immediate past history revealed that she had had a sore throat and a mild fever about one week prior to the present illness.

She was admitted immediately to the hospital, where it was determined that the leukocyte count, temperature and sedimentation rate were definitely elevated. No other evidence of disease could be found, except the chronically infected tonsils.

An early diagnosis of rheumatic fever was made and penicillin was started at the rate of eight hundred thousand units every eight hours (Penicillin SR). The temperature and joint symptoms subsided rapidly and no evidence of the rheumatic process could be made out within thirty-six hours. She was discharged to her home to take one hundred thousand units of penicillin by mouth seven times in twenty-four hours. This was continued for a week.

CASE III

J. B., white male, age 14, entered the hospital January 4, 1949, with the diagnosis of acute rheumatic fever.

His past history revealed that he had always been well except for a fractured wrist in October, 1946.

His present illness started during the last week in December, 1948, when he had a strep throat and was treated at school. His throat had remained raw ever since that time.

On December 31, 1948, the patient noticed soreness and tenderness in the joints. The following day the soreness in joints and feet was more severe. It soon spread to his knees.

On admission to the hospital his temperature was 100.6. The W. B. C. was 12,450. There were 66 segs, 3 stabs and 29 lymphs. The sedimentation rate was 31 mm. the first hour. He was put on large doses of penicillin on January 4 and the temperature promptly fell to normal on January 6 and remained there. He was kept in the hospital for eight days, receiving penicillin all the time. His joint symptoms improved and soreness was gone by the time he left the hospital.

He has not had any recurrences to date and has remained clinically well.

The following table will summarize the results of these early cases which I have treated, all having been diagnosed in the early stages.

It was observed early that three-week-old cases required longer to render symptom-free and required continuing the treatment much longer after they became symptom-free in order to prevent relapses. One case of subacute rheumatic fever and the other chronic rheumatic fever will be reported briefly to illustrate the difficulties en-

Days Ill Before Treatment	Afebrile In	Asymptomatic In	Hospitalized	Average Total Penicillin Used	Recurrence	Clinically Well
1 to 5 days (11 cases)	1.5 days	2 days	5 days	7,000,000 units	0	10 days
7 days (3 cases)	1.7 days	6 days	7 days	8,000,000 units	0	14 days
14 days (3 cases)	3.5 days	11.5 days	19 days	8,600,000 units	1*	25 days
21 days (2 cases)	4 days	6 days	20 days	11,200,000 units	1**	30 days

* One case, who had been sick two weeks, had penicillin dosage reduced too soon. She had a relapse and had to be treated all over again.

** One case, who had a recurrence, had his penicillin stopped by mistake after five days. His treatment should have continued at least twelve more days.

countered with these older cases. I have not had the opportunity to treat the subacute and chronic cases as vigorously as they should be. They might be helped if one would treat them as intensely and as long as cases of subacute bacterial endocarditis are being treated.

CASE IV

A white female, age six years, entered the hospital September 3, 1949, with the following history: She had been ill since May, 1949, with chronic tonsillitis, subacute joint symptoms, and a heart murmur had recently been noticed by her family physician.

Past History: Scarlet fever at the age of six, chronic tonsillitis with repeated exacerbations, with indefinite joint symptoms, at different times.

Examination at the time she entered the hospital revealed some painful and sore joints and marked chronic tonsillitis, elevated temperature, pulse rate, sedimentation rate and leukocyte count. There was a definite mitral stenosis of more than a mild degree. The electrocardiogram was normal. X-rays of the chest indicated a prominence in the region of the pulmonary conus, suggestive of a mild lesion.

She was given the usual penicillin therapy. The temperature, however, persisted. The tonsillar swelling and redness subsided. Tonsillectomy was performed on September 19, 1949. Following this the penicillin was continued but the temperature kept up during the remainder of her stay in the hospital, running as high each day as 100.6. She was discharged from the hospital five days after her tonsillectomy, continued to take penicillin by mouth for another week. A low grade temperature persisted and the child was barely able to return to school for the second half of the year beginning in January, 1950.

CASE V

B. H., white female, age eight years, entered the hospital November 18, 1949. The history revealed chronic rheumatic fever of approximately three years' duration. Fever, joint symptoms, repeated sore throats, many admissions to Riley Hospital, and a rheumatic heart had all occurred in the three years.

Physical examination revealed an anemic, emaciated, white female, who looked like a six-year-old girl in size. There were some mildly sore joints, large chronically infected tonsils and several carious teeth. There was a typical mitral stenosis with enlarged right heart and left auricle. Laboratory findings showed normal blood count, normal sedimentation rate, normal urine, and an electrocardiogram with typical right ventricular preponderance and very large T waves. The PR interval was not prolonged. X-ray of the chest confirmed the diagnosis of enlarged right ventricle and left auricle. The temperature on admission, November 18, 1949, was 100.8. It continued at this height until November 24 (six days) despite penicillin therapy. At the end of six days the temperature fell to 99.6 and continued at approximately this level until the dismissal on December 10, 1949.

The tonsils and carious teeth were removed on December 2, 1949. This did not produce any noticeable change in her condition.

After dismissal from the hospital the temperature continued to be low grade but gradually lower. Recently she had improved appetite. For the first time in three years she has gained weight, averaging one pound each week. There is definite clinical improvement after four months.

COMMENT

Those cases without cardiac complications at the beginning of their treatment did not develop any such manifestations. The hearts of those who had old cardiac conditions, i.e., mitral stenosis, were not affected by their new rheumatic infection. One case definitely did have early rheumatic heart findings before treatment was started, i.e., murmurs and electrocardiographic evidence of myocarditis and pericarditis. These complications disappeared within three weeks following completion of the treatment. There have been no failures in any of the early cases of rheumatic fever in which there was a history suggestive of an antecedent streptococcic infection.

Nineteen cases may not prove much. I think they are worth reporting, however, because the treatment, to be effective, must be started early in the course of the disease. The general practitioners, who see these cases in the beginning stages, are the ones to diagnose and institute early treatment. If any such cases are so treated I would consider it a distinct favor to learn of the successes or failures.

SUMMARY

Nineteen cases of acute rheumatic fever have been successfully treated with penicillin without any demonstrable cardiac damage. Further study certainly is in order, and the early diagnosis and early treatment rest upon the shoulders of the family physician.

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THE JOURNAL

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Office of Publication: 1017 Hume Mansur Building

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Editor Emeritus: E. M. Shanklin, M.D., Hammond, Indiana

Editor: Frank B. Ramsey, M.D., 201 Hume Mansur Building, Indianapolis 4, Indiana.
Associate Editor: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana.
Managing Editor: Ray E. Smith, 1017 Hume Mansur Building, Indianapolis 4, Indiana.
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GENERAL PRACTICE OF MEDICINE ISSUE

ACKNOWLEDGMENT is made to the officers of the Section on General Practice who, under the guidance of Dr. Clarence H. Rommel, chairman of the section, have served as guest editorial board, in planning and editing the scientific and special articles for this issue. Many of the papers have been written by special request for the General Practice Issue; others have been selected from the accepted papers of THE JOURNAL for publication this month because of their particular scientific interest to the general practitioner.

Due to limitation of space two of the chosen articles cannot be included herewith, and will be published later.

The regular staff of THE JOURNAL wishes to present this issue as its tribute to those of its readers who are engaged in the general practice of medicine, and to thank the officers of the Section on General Practice for their cooperation and assistance.

DOCTORS AND POLITICS

THE medical profession's campaign against compulsory health insurance and socialized medicine has now progressed through several phases. At its inception it was mainly concerned with presenting the true facts to our representatives in Congress. The development of a universally available form of voluntary health insurance was also one of the early objectives.

The success of the campaign as related to members of the Congress became evident late in 1949, and is now even more apparent. Its success has led the advocates of compulsory health insurance to introduce the question of government-controlled medicine as an issue in political campaigns for the election of congressmen.

The A.M.A. National Education Campaign in 1950, therefore, is continuing its efforts toward the education of the people; it is redoubling its work on behalf of voluntary plans; and it is encouraging the medical profession to do its duty as individual citizens in the political campaigns to elect representatives who are opposed

to socialized medicine and to socialism in all its aspects.

The medical profession has welcomed the opportunity of carrying this issue to the people. One reason for this is that it is the only democratic manner in which the question may be settled. Another advantage is that it will produce a more decisive and longer lasting effect upon the forces of socialism. If the controversy can be settled at the polls it will lessen the necessity of repeated campaigns for the purpose of acquainting our congressmen with the opinions of the people.

Doctors already have been given credit for influencing the outcome of elections in which the candidates have taken a clear-cut stand on each side of the government-controlled medicine issue. John P. Saylor was elected to Congress in the 26th district of Pennsylvania, and George Smathers won the senatorial primary in Florida. Each of these men made socialized medicine an issue in his campaign, and each had the support of the doctors and their friends who were organized into political action committees.

The 1950 congressional elections will be decided in part by the voters' decision on the issue of socialized medicine. It has become the duty of each individual physician to campaign as vigorously as he can for the candidates who favor freedom for the practice of medicine, and to oppose as vigorously as he can the candidates who favor the socialistic control of medicine.

The law is explicit on the conduct of political activity. Legal opinions have been prepared which set out the limitations as applied to the profession. (See page 788.) Medical societies may not engage legally in political campaigns. However, individual doctors may, and in fact it is their solemn duty as citizens to see that the people are well informed on this particular question. Individual doctors may form committees for this purpose and may contribute financially, within limits, to these committees or to candidates whom they favor.

The American way of life is being threatened by the forces of socialism. The present political campaign may determine the pattern of American life for many years to come. Enlightened political activity is so important now that busy doctors will not "find" the time to devote to it; they must "take" the time from other pursuits to fulfill their obligations as citizens.

THE G.P. AT THE CROSSROADS*

THE amount of money being spent on hospitals, specialists, eyes, and teeth obscures the most important problem of modern medicine—the status of general practice. General practice is at the crossroads. The general practitioner sees himself being elbowed out of the hospital, finds himself more isolated than ever before from his colleagues in specialist and consulting practice, is plagued with paper work, and sees little prospect of obtaining those pleasant conditions of work so alluringly offered to him by the propagandists for the National Health Service during the years before July, 1948. In the absence of hard constructive thinking and action flowing from it there is a grave risk that general practice will deteriorate and cease to attract into its ranks a goodly proportion of men and women of first-class ability—the men and women who set the high standards for others to follow. It is infinitely harder to be an able general practitioner than to be an able specialist. Yet in the N.H.S. the bait is set to attract the latter and almost to repel the former. Modern medicine has put in the hands of the general practitioner a wide range of exact diagnostic techniques and an armoury of powerful drugs. To be able to use these in the conditions of general practice calls for higher qualities and a greater resourcefulness than are required in any other branch of medicine. Yet peculiarly little is being done to face these problems squarely or to try to determine consciously the direction general practice shall take. Standing at the crossroads, the general practitioner may by turning in one direction become little more than a medical orderly, or by turning in another direction may be tempted to become a half-fledged specialist. If he is to go forward to occupy the most responsible position in the practice of medicine fully equipped and with confidence in his high calling, he must pause and take stock of a situation which in the view of many shows signs of rapid deterioration.

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* Excerpt from an editorial in the British Medical Journal of March 25, 1950.

President's Page

CALIFORNIA COASTAL SURVEY

THE American Medical Association convention developed into a very important meeting. Many vital subjects were discussed and then disposed of or endorsed.

The Hess Report, which deals with medical ethics, was very thoroughly discussed and was adopted as amended, with one year of time allowed for getting it activated and put into operation. The Whitaker and Baxter contract was renewed for another year in order to continue the education campaign, which is to be stepped up greatly in October. The coordinating committees of the various states—particularly our own committee headed by Dr. Cleon A. Nafe—have done fine work in education against socialization. The national and all state medical service committees are to increase their activities.

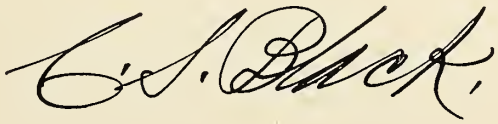
Both President Henderson and President-Elect Cline made very positive statements in regard to socialized medicine, stressing that NO doctor should support any candidate with socialistic tendencies.

Indiana is to be commended for the splendid attendance of medical men and auxiliary members. We are proud of Mrs. Frank Gastineau of Indianapolis, who was established as a member of the official family of the A.M.A. Auxiliary.

There were 10,200 physicians registered at the convention. Auxiliary members and guests brought the total attendance up to 22,000.

After leaving San Francisco, we wended our way southward to San Diego where we saw all types of ships leaving port, presumably for Korea and the Far East. A great number of marines were shipped out from San Diego; air force units left from March Field. All this activity and movement of personnel may well mean that very soon the government will need additional medical personnel for its armed services.

Because we are all concerned with our professional and national welfare, we should heed the words of Dr. Ernest E. Irons, retiring president of the American Medical Association, who said in his farewell address: "On the basic principle of freedom for American medicine, and freedom for America, we cannot compromise." This statement should be the golden rule for all medical men.



Medical Panorama by the Associate Editor

CIVILIAN DEFENSE PROGRAM

Civilian defense is again coming to the fore in the local news and in planning the medical share of this project, Hoosier physicians might be interested in an editorial prepared for *The Nebraska State Medical Journal* by Dean Harold C. Lueth, of the Council on Emergency Medical Service of the A.M.A., and published in the July, 1950, number. Excerpts follow:

While the total number of patients in need of care may become large during certain seasons or during an epidemic, the doctor generally sees a more or less regular and even flow of patients requiring hospital or office treatment. There are facilities for emergencies as a rule and when they do arise the victims are given special priority. However, only a limited number of such cases can be handled in any community before these new loads put severe strain on medical and hospital staffs and equipment, with the threat of a complete breakdown.

A number of state medical societies have become concerned with the problem and have formulated sound emergency medical service plans. Shortly after the cessation of fighting in World War II, the House of Delegates of the American Medical Association felt that a careful study of aerial bombardment, atomic, biological and other types of warfare should be made a continuing function of the Association. The Council on National Emergency Medical Service was created and charged with the development of sound plans for comprehensive medical care of the nation in the event of emergencies. The Maine Medical Association through its Committee on Emergency Civilian Medical Defense has developed a sound program for all types of emergencies, civil or military. The Illinois State Medical Society through its Committee on Military Affairs and Emergency Medical Service is planning comprehensive medical service for all future emergencies.

Emergency Medical service requires close coordination with many other civilian and governmental groups including: police, fire, utilities, rescue workers, American Red Cross, state militia, sheriffs, state police and at times army, navy and air force personnel. The "Hopley Report" prepared under the leadership of the late Mr. Russell J. Hopley of Omaha will undoubtedly serve as a blue print for all future planning. Within the medical groups there must be unity of action among physicians, dentists, nurses, hospital administrators, hospital staffs, medical technologists, x-ray technologists and auxiliary nursing workers. Emergency medical service may require the services of each physician to meet the needs of a disaster. It is hoped that every member of the medical profession will accept this obligation of duty to the injured and sick and thus relieve unnecessary suffering among the unfortunate victims of future disasters.

Civilian defense against military attack is not the only use for such organization, since other types of disaster can happen anywhere.

Recently there have been some major disasters that have made doctors more aware of their responsibilities for providing adequate emergency medical service. The Texas City, Texas and the South Amboy, New Jersey explosions dramatically illustrated the need for advanced planning. In Chicago the recent tragic fire after the collision of the gasoline transport and the loaded street car showed that serious accidents could occur in almost any community.

We boast of giving complete medical care to our people, yet there must be many communities where the machinery for combating a disaster is a bit rusty, and still others where no such "machinery" yet exists. Is this not a field suitable to leadership by the general practitioner, with specialists assigned where they will be most useful? Can the physicians of any community shun the duty of participating in this program?

The schedule for the Instructional Course Program will be found on page 791

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

EXCERPTS FROM EDITORIAL IN MAY 15 ISSUE OF THE UNITED MINE WORKERS' JOURNAL

On the medical question, labor had better begin to think, because if resentment of the voters to national medicine in one-third of the states proves as beneficial to reactionary candidates as in the case of Smathers, the problem of repealing the Taft-Hartley Law—so long as both are linked in the Truman program—will be three times as difficult.

Regardless of how lightly President Truman may seek to brush off the Pepper defeat, the fact remains that the over-all resentment against Pepper crystallized as a result of Pepper's all-out support of the Truman program.

Pepper had to bear the brunt of all the fault-finding levelled at the Brannan Plan, foreign aid, give-away money, point four, lowering of tariffs, Government extravagance, "Commie" influence in Government, Kansas City graft, FEPC, Repeal of the Taft-Hartley Law and, of course, national medicine.

The heretofore unorganized vote, as a result of the Truman Medical Plan, the FEPC, the raging "Commie" publicity and bitterly contested Brannan Plan, was activated into resentful political action as never before—resulting in a record vote.

In 44 years of covering political campaigns in the nation and in many states, your editor has never witnessed such effective and productive quiet solicitation of votes as demonstrated by Florida doctors, druggists, dentists, hospital staffs, insurance companies and pharmaceutical representatives, aided and abetted by other professional men.

Funds were quietly raised. Golf matches, poker games, bridge parties and every form of contact which could be conceived and arranged were executed by the medical, drug and hospital fraternity to convince the people that epidemics would be the order of the day, plus bankruptcy, in the event the proposed Truman Medical Plan—which Pepper was supporting—was enacted into law.

Generally speaking, the people in the East, North and West look upon Florida as a state of aged pensioners in need of medical attention that they cannot afford. This is only partially true as affecting the aged. But they do not constitute an appreciable percentage of the voters.

Pepper was up against an unreasoning wall of voters on this question and the more he said in support of National medical aid the more votes he lost.

NICKING PAY CHECKS

Candidate John Beamer, who is one of the four men seeking the Republican nomination for congressman from this district, tells the story of a discussion he had with a man whose vote he was soliciting. It related to the nicks that the government is taking in workers' pay checks and the larger slices of those pay checks that would come if new programs like socialized medicine would be adopted by Congress.

The man, says Beamer, apologized for the condition of his house and explained that he had been trying to remodel it but had been unable to do so because he had to use his money to pay for an operation his wife had. In discussing that illness, the man said he thought at one time that perhaps it would be good to have received some health or sickness benefits, since the medical and hospital bills were large.

However, the voter changed his mind after considering the prospect further. He figured that 1½ percent was being taken off his pay check for social security and his employer was paying a like amount by adding it to the price of its products. In that way, the consuming public actually is paying the company's 1½ percent, the man reasoned.

Then he wondered what socialized medicine would cost. Beamer replied that no one knew but there were all kinds of guesses—estimates ranging from 3 to 13 percent. The voter wondered whether the firm for which he works would continue to pay its share of that cost by raising the price of its products still more.

Beamer suggested that the lowest estimated figure be considered in contemplating how much of a man's pay check would be taken off to pay for socialized medicine and increasing costs of social security. The lowest figure, he suggested, would be 6 percent, and the worker would be paying all of it because as a consumer he would pay for any increase in products. The man then figured that at 6 percent he would have been able over the past 10 years to have had several operations and paid for them easily, to have done all his remodeling and still had money left.

—*Kokomo Tribune.*

FIFTY-SEVEN GLORIOUS YEARS

Charles C. Crampton, M.D.

DELPHI

JUNE 22, 1950, marks my fifty-seventh year in the practice of medicine in the same town, Delphi, Indiana, and the same county, Carroll. It has been a glorious fifty-seven years, and it is pleasant to reflect on the changes: from horse and buggy to automobiles; from a summons "Hurry, Doc," brought by a boy on horseback, to the modern call by telephone; from quinine, the cure to all ills, blue mass, calomel, aconite, veratrum, gelsemium, hyoscyamus, and the bromides, to cold tars, acetanilid, phenacetin, salol and aspirin; from vaccines and antitoxin to sulfa drugs, sulfathiazole, sulfadiazine, and then . . . antibiotic, penicillin and chloromycetin. It's a far cry from wine, beef and iron to the vitamins, and as I reminisce today I wonder would I have "got my growth" just the same if I had started at the age of twelve to smoke Camels instead of chewing Star tobacco, and if we had known more about vitamins and less about sulphur 'n' mollasses.

As I look back, I marvel at the transition from bedside diagnosis, temperature, tension of pulse, color of skin, posture of patient, palpation and auscultation, to the sphygmomanometer of today, to the laboratories with their Wassermann, Widal, cardiograph, metabolism and x-ray; from feather beds and granny midwife, the coal-oil lamp, a pan of water, a cake of soap and a towel, with sleeves rolled up . . . to the present white, bright delivery room, mask, sterile gowns and rubber gloves, with pretty nurses to lend a hand; from "ten days flat of your back" to early rising; from "good old country milk" with a barnyard flavor to pasteurized or condensed milk every three hour feedings.

Happily have we lived through the era of dining room table surgery with ether or chloroform anesthesia, down to the present with its tiled operating room, reflected lights, and trained assistants; nurses to thread your needle or assist with gas or spinal anesthesia.

Yes, it has been a glorious fifty-seven years. I have had my share of success and of failure. There have been trials and tribulations. I have enjoyed it all. In fact, with the progress medicine has made, with the training and the internships and the present-day hospitals (where, experience tells us, life begins, life ends and life goes on) I sometimes wish I could do it all over again. To the younger men who have just ahead of them a future of marvelous significance, may I suggest this bit of advice: For the richest reward, let medicine be your hobby, not forgetting to keep service ever ahead of self.

OUR COUNTRY'S RURAL HEALTH

Frank G. Sink, M.D.*

REMINGTON

THEODOR MOMMSON, famed German historian and Nobel Prize winner, said this about the United States, "You have had the history of the world open before you ever since the beginning, and you have consistently copied every mistake Europe has ever made." Now there are many in high government positions who would copy another European mistake, government medicine for all the people. Much has been written and said about the poor distribution of physicans and the general shortage of doctors in rural areas. Appeals for the support of a government medical program have been made to the people of the rural communities, through promises of more physicians, better hospital facilities, and complete, immediate and free medical care.

The Rural Health Committee of the Indiana State Medical Association has accepted the responsibility of studying the rural health problem to determine if conditions exist as charged. We have met with representatives of rural organizations to discuss rural health matters, to gain first-hand knowledge of the thinking of rural people in the field of health. As a result of these discussions, your committee feels that it now has in the making a program that will provide at least a partial answer to the overall problem. With the understanding and cooperation of the members of the association, we believe all present and future problems may be solved through mutual understanding and cooperation at the local level.

* Chairman, Rural Health Committee, Indiana State Medical Association.

Dissatisfaction was expressed in three areas with the rural medical care service. First and foremost of these was the feeling that there were not enough physicans in rural areas. It was agreed that it is possible that there are sufficient doctors, but one point upon which the rural leaders agreed is that either there should be a redistribution of physicians or else more should be trained so that the rural communities could have the benefit of more doctors.

People in rural communities are having a hard time obtaining the services of physicians, and when they do the charge made for the service is making the cost of medical care rise for these people, it was stated. Examples were cited in which the doctors are reluctant to make country calls, requesting the patient to be brought into town. Many of those who do respond to rural calls charge as much as fifty cents a mile each way, plus a sizeable fee for the call. This makes the cost of medical care much higher for people in the country. Rural leaders stated that this was not true of every doctor who accepted country calls, as many of them were going out of their way to serve rural people expeditiously and economically.

One other finding which reflects very poorly upon the profession as a whole has been the failure of some medical societies to accept the invitation of rural leaders to participate in discussions of community health projects. One county was cited in which the rural people had asked the county medical society to meet with their group to discuss some of the problems facing the people in that community. The county society ignored the invitation, and also ignored a later request to permit representatives of the rural leaders to meet with the county society. As a result of this experience, the rural people of this one county feel that the medical men of their community are uncooperative and uninterested in anything except charging an excessive fee for their services.

Rural people are vitally interested in matters of health. Education and the ease of transportation have shown the people of rural communities that they, too, can have the same social advancement as their city cousins. Today electricity, the telephone, and modern mechanical time-saving and labor-saving devices have been made available for use in the rural areas as well as in urban areas. Now much attention is being focused on improving the general health of rural people.

Farm organizations and school organizations have included health topics as a part of their study programs. Extension services have done much to educate the farmer on the value of sanitation and animal husbandry, while the economics clubs and home demonstration agents have been conducting intensive education programs among farm women on home sanitation, food sanitation and preparation, and family health. These programs, however, can go only so far under lay direction. Ultimately the time arrives when they must depend upon the medical profession to advise them on sound health practices. Today they are looking to our profession for this help and expecting our fullest cooperation. Their confidence in the medical profession cannot be dulled through our lack of assistance; in fact, we should offer our services, and help in every way possible through participation and consultation in the development of constructive and worth-while health programs that individuals in the rural communities can put into practice.

Following a recent conference with the rural leaders of Indiana, your committee drafted a plan of action which has been approved in principle by the association. This plan has a two-fold purpose. One purpose is to provide state, regional and county level organizations, through which discussion of rural health problems may be held between lay and professional leaders. These discussion groups will serve in assisting in the planning of health programs. Here the problems, as the rural people see them, can be laid before medical authorities, and the medical profession can place its problems before rural leaders, with the result that solutions can be made without the necessity of outside and federal intervention.

The second purpose of the plan is to provide a means of health education for rural people. It is planned that this be done at the state, regional and county levels. County societies are being requested to establish health committees which will serve as liaison between the profession and the community on all health problems and movements. One feature of the latter program was demonstrated in the first state-wide rural health conference which was held at Purdue University, Tuesday, August 1, 1950. This was held in conjunction with the annual Farm and Home Week program of the University, which drew an attendance of more than five thousand farm people from throughout Indiana. An impressive program was arranged which included both professional and lay participation. Through this effort we hope to bring about a better understanding of our mutual problems, and to prove that medicine is ready and willing to assist the people of rural communities in working out their local problems through individual initiative and mutual cooperation. Establishment of county health councils was advocated as the vehicle for bringing the thinking of rural people together with that of the medical profession, and providing a means of working together in bringing rural health facilities and medical care to the proper level.

Obviously this is an ambitious program, and a program that can be successful only if the medical profession lends its complete assistance. This as-

sistance will probably be shouldered, of necessity, by the general practitioner, for he is the representative of medicine who is in close contact with, and provides the great share of medical care to the people of rural communities. The understanding and constructive assistance of every physician is needed to produce through this program advances in rural medical care. If we are to maintain the confidence now placed in us by these people, it means that we must work diligently and take the lead in bringing about a better understanding of health and our problems in making better medical care available to the rural communities of our state.

Through this program the medical profession has a positive means of convincing all that medicine can and will work with people to solve each and every health problem. Our initiative in this will be contagious, by producing the required initiative on the part of lay people to solve medical care problems, without the necessity of other outside agencies stepping in to solve them for us through compulsion and federal control of the profession and the pocketbooks of the farm people.

MY VISIT TO EUROPE

Karl R. Ruddell, M.D.

INDIANAPOLIS

IT WAS my good fortune to visit Europe recently. I was one of a group sponsored by the Foreign Trade Division of the Indianapolis Chamber of Commerce, and we had the benefit of the interested aid of the Departments of Commerce and State, as well as the endorsement of President Truman. Also, through the capable machinations of Mrs. Lillian Kreps, we not only had the active interest of the Chambers of Commerce in all of the countries that we visited, but we were well received by the members of the ECA missions and the embassies.

In our group were men interested in banking, housing, construction, agriculture, poultry, manufacturing, dairying, insurance and exporting. Through question-and-answer sessions with the groups first mentioned, we were able to get a pretty good composite picture of the economic, social and physical conditions of each of the countries.

We also learned more about the Marshall Plan—what it hopes to accomplish—how it is administered—and what it has accomplished. I am sure we were all impressed by the caliber of the men who headed the ECA in all of the Marshall Plan countries; Gross in Norway, Marshall in Denmark, Bingham in France, Gilchrist in London, Harriman, the Roving Ambassador, and all of the other men were successful American businessmen. None were politicians.

Generally the morale of the people of the countries we visited was high, with the probable exceptions of England and Germany. Most of them knew that their relative prosperity was due to the Marshall Plan. They knew that only because of it were they able to have jobs and to have food to eat, but all of them wondered how long it would last, and what would happen when it stopped. It is a great mistake to believe that the people of the Marshall Plan countries are being pampered, and that they are lazy, or sitting around while America feeds and keeps them. The opposite is true. Because of the Marshall Plan they have work and food. It is well to remember that all of the money spent by America is spent under the supervision of ECA, and only for two things: food and reconstruction.

As a small example, get this picture! The war had ended four years ago. By the time we arrived the people had passed through periods of anticipation, disappointment, near collapse, and now were working toward self-reliance and economic security. Perhaps it is well to think of what these people had to do. In Norway, the economy had been supported by shipping and mining. During the German occupation 60 percent of the shipping had been lost and the coal and iron mines were destroyed. In addition, the homes of the miners had been flattened and the currency had been inflated by the issuance of printed money which the Germans used to pay for the cost of occupation. In Holland the Port of Rotterdam had been nearly destroyed by bombs, and in all of Holland the equipment had been removed. For instance on one pier which had 60 cranes for unloading cargo, only one was left. Also, all of the faucets were taken from private homes and every piece of metal was sent to Germany. In Denmark and Holland all of the police, and many of the managing executives, were sent to concentration camps. Many of them

died, and others were rendered unfit for work. Also, workers learned how to work slowly and poorly because it was patriotic to hinder the Germans. Much of the land in Holland was flooded. In spite of these handicaps—bombed factories, broken machinery, poor working morale, the absence of managing personnel—Europe is producing more than it did in 1939. Not to detract from the spirit of the people themselves, this most certainly could not have been accomplished had it not been for the Marshall Plan aid. We learned in Italy, 98 percent Catholic, that the leaders of the church gave credit to the Marshall Plan for defeating communism in Italy. So much for the Marshall Plan. I hope it continues to succeed.

As for medical practice in Europe, it is largely socialized, according to American standards. This trend was originally started by Bismarck in Germany as far back as 1886. At that time the hospitals were nationalized and conducted under the system of the Krönkenhausse. There was a doctor at the head of each department, known as the professor, paid by the government. His assistants advanced by virtue of death of their immediate superiors. The system of government insurance was also introduced at that time. That was the beginning of state or socialized medicine in modern times. I shall not try to discuss the merits or weakness of that system at this time. Instead, I shall try to give a factual description of medicine as I saw it in the various parts of Europe.

I was privileged to visit hospitals, and observe both surgical and medical practice in all of the countries except Denmark and Belgium. While the hospitals generally were very old, they were kept in good repair and facilities were adequate, if not luxurious. The surgeons I met were very courteous, capable, and without exception impressed me as being gentlemen of fine character. Their chief ambition was to visit America. In Oslo I visited the Ulleval Hospital, 2,000 beds, where I observed the Chief Surgeon, Doctor Semb, do a gallbladder operation, and his first assistant, Doctor Brusgaard, resect a stomach for peptic ulcer. By the way, ulcer is extremely prevalent throughout Europe, probably reflecting the poor dietary conditions and the anxiety of the people. Doctor Brusgaard told me he received a salary from the state that amounted to about $2,000 yearly, and $1,000 from the city. That was before devaluation, so you can readily see why he traveled by bus and bicycle. About 70 percent of the people of Norway have voluntary sickness insurance; accident insurance is compulsory.

In Sweden 60 percent of the population is now covered by health insurance, provided by 1,600 local voluntary health insurance societies. The State Pension Board supervises the work of the societies and is responsible for the disbursement of subsidies now amounting to 50 million crowns a year. Every employed person in Sweden is compulsorily insured against accidents, including occupational diseases. This insurance is carried by the employer. Universal compulsory insurance is now scheduled to go into effect on July 1, 1951. This includes free hospitalization and medical care and will be a direct concern of the state. In addition, the act provides for a daily sickness allowance of 3.50 crown. Sweden's population of about 6 and ¾ million is served by 4,250 doctors—6 for every 10,000 inhabitants. The United States has 14 per 10,000 inhabitants.

Stockholm, with a population of about 700,000, has more than 7,000 hospital beds. Marion County, with a population of more than 500,000, has (counting the University Hospital, which is largely used by the state) about 2,600 beds. I asked Doctor Sorensen how he thought the new plan would work and he, perhaps facetiously, remarked that there would be just two classes of people in Sweden—the sick and those who were taking care of them. He explained that the people of Sweden were about the same in their behavior as those of other countries.

In Denmark insurance is partly voluntary and partly compulsory, but it is provided by private companies, and the patient has free choice of physicians.

In The Hague I saw two very good gastric resections in a semi-charity hospital run by the Lutheran Church. The surgeon, a very fine man, told me that about 80 percent of his work was free, and that he made his living from the remaining 20 percent, either as private patients, or those covered by insurance.

In Frankfort medical practice was completely socialized and was in a rather deplorable condition. Many of the hospitals had been bombed out, and the large university hospital had suffered the loss of one wing by bombing. The equipment left something to be desired.

In Zurich about 90 percent of the people are covered by insurance, and hospital practice is fashioned after the German Krönkenhausse. The state is building a new university hospital.

In Rome medicine, like most everything else, seemed to be in a state of confusion.

I visited three hospitals in Paris: The Hotel Deau, founded in the time of Charlemagne; a clinic hospital where private patients were sent; and the American Hospital, founded and endowed by Americans after the first World War. It is the finest hospital in Europe, with the possible exception of the South Hospital in Stockholm.

In all of the countries I visited the doctors voiced the hope that medical practice would not come under the blight of complete socialization now in effect in England. It can readily be seen that in countries where the average income of such a large percentage of the population is $40.00 per

month and under, as it is throughout all of Europe, there is very good reason for a high degree of socialization of medicine.

One can also see the need for other social services provided by the state, such as maternal care, the feeding of school children, old age pensions, and unemployment reimbursements.

So too in England there have been many contributing factors that may be cited as excuses for the Cradle to the Grave Security Act, and the national trend toward complete socialization.

England has been through two devastating wars, and many of her colonies have been lost. Industrialists too often milked their industries instead of ploughing enough money back to keep the companies sound.

When England was prosperous the wealth was in the hands of a comparative few, so that large hospitals were established and endowed to furnish free hospitalization to the great majority of the people. Private hospitals, called nursing homes, were provided for the patients who could pay, and this class of hospital bed has always been very much in the minority. Between the wars the endowments gradually dried up until by the end of the last war they had entirely disappeared. Naturally the government had to take them over. Considering the fact that the panel system of free medical care had been established after World War I, it was a short step to complete nationalization of medical practice.

How will it work out? I don't know. Many tales are told, some of them true, some of them false or exaggerated—like the sailor who had his teeth pulled and obtains dentures, then sells them in China and comes back for more—or the lady who wanted a new seat for a wheel chair and after going through fifteen agencies, requiring many months, ends up with a new motorized wheelchair. At a luncheon given by the Chamber of Commerce in London I sat next to a representative of one of the New York banks. He was a little on the bald side and said he believed he'd take time out to get a free wig.

I talked to several members of the staff at Guy's Hospital. A 30-year-old anesthetist thought he was fortunate because he was being paid 1000 pounds, at this time $2800, for working four sessions of six hours each. Before nationalization his work there would have been charity. Doctor Doherty, chief of staff of the hospital, and a very capable surgeon, gave a very different picture. Sincerely and dispassionately he described the situation. He said that while formerly he had done this work at the hospital free, he is now paid so much per session; his work necessitates a secretary, and the secretary has to have a stenographer and an assistant stenographer, and so on. He said that whereas the man in general practice formerly took pride in his diagnosis and did many small things, like sewing up a cut finger or opening an abscess in the office, that now it meant little or nothing to him, so he would neglect making the diagnosis and send the patient to the outpatient department. He thought the present system would attract the wrong type of individual into medicine. He declared that he would not consider taking up the study of medicine under the present system. However, the energetic young man in general practice fares better than any other type of citizen under such a socialized government. The dentists and opticians, perhaps by slightly devious methods, fare exceedingly well.

What of the patient? I'm inclined to believe he gets just about what he pays for. While the ethics of the English medical profession have been very high, the lack of incentive is bound to have its ultimate effect.

We happened to be at a meeting with the ECA in Paris the day Mr. Bevan gave his report on the cost of the first year's medical service plan. It amounted to ONE BILLION, TWO HUNDRED MILLION DOLLARS, or about $30.00 per capita. Had the full facilities been available, the cost would have been 50 percent more. I asked Mr. Averill Harriman if he thought England's economy could stand that cost, and he said he didn't think it could. He thought England had gone much too far in its social services. I also asked the president of the British Stock Exchange if he thought the economy could survive such costs, and he replied that "without American aid, it could not."

It seems to me that the Briton has tried to trade his liberties for security and it just can't be done. Without the FOUR BILLION, FIVE HUNDRED MILLION DOLLARS America gave England after the war, plus thirty-some percent she receives under the Marshall Plan, England would be completely bankrupt, and the Briton would have neither liberties nor security. The most heartening news I have seen is that the New Zealand voters have turned away from the socialist state, as being impractical.

American medicine has its challenge. I would be the first to admit its imperfections. I couldn't agree with Mr. Ewing that we have too few doctors, but I must admit we have too many trying to enter specialties. This has been brought about partly by the Army and the Veterans Administration giving marked preferment to those passing Specialty Boards. I know that medical care is very expensive in this country, but much of that cost is due to expensive scientific research and high hospital costs. In 1915, when I had occasion to investigate hospital costs, the per diem rate ran from three to five dollars. Today the average cost is something over twelve dollars per diem. I also realize that the high cost of medical care falls heaviest on the middle class citizen. The indigent may receive very good medical care most anywhere in the United States. For the catastrophic illness affect-

ing members of the lower and middle income group, I have long advocated nonprofit hospital and medical insurance on the same principle as the fifty dollar deductible automobile insurance. To pay all the cost encourages malingering. Such insurance is now available through the Blue Cross and the Blue Shield. It is also being written for groups by private insurance companies at a reasonable cost. I believe that most workers in America can pay for ordinary illness. The Blue Cross now has insured more than 34 million persons, and the Blue Shield, a very young organization, more than 12 million. I will admit that we are shy of private hospital beds. Nowhere is that more true than in Marion County. We have for the taxpayers who pay their own hospital expense about 1,280 private beds. Practically no new beds have been added since 1929. Communities with a like population, for example Milwaukee, has twice the number of private beds. Please excuse this as a plug for my pet peeve!

What does Mr. Ewing want? It is difficult to read the bill and find out. He says his plan is not socialistic. Perhaps not entirely, though it is my sincere opinion that within five years after its passage the United States will be entirely socialized. I believe that compulsory medical insurance is not alone the fight of the medical profession, but that of every citizen in this country who doesn't want complete socialization. Having been a life-long Democrat, and not a disgruntled politician, I believe with Jimmy Byrnes that the government should call a moratorium on social security and cut government expenditures to the end that we shall not be taxed into national socialism.

THE RESPONSIBILITY OF AMERICAN MEDICINE*

ELMER L. HENDERSON, M.D.

LOUISVILLE, KENTUCKY

In the annals of American medicine, this is a historic occasion. Tonight the American Medical Association, in its inaugural ceremony, is speaking not just to doctors, but to the American people—on two nationwide radio networks, reaching into every state and into every corner of the country.

There is a vital reason for this new policy. Our affairs are no longer just medical affairs. They have become of compelling concern to all the people. American medicine has become the blazing focal point in a fundamental struggle which may determine whether America remains free or whether we are to become a socialist state, under the yoke of a government bureaucracy, dominated by selfish, cynical men who believe the American people are no longer competent to care for themselves. In view of the challenge which confronts us, it is with a deep sense of responsibility that I begin my year of stewardship as president of the American Medical Association.

American medicine, which has led the world in medical advances, and which has helped to make this the healthiest, strongest nation on the face of the globe, has been made the first major objective of those ambitious men in Washington who would make the American people walk in lockstep under a rigidly controlled, government-dominated economy.

The American medical system has been made a target for the barbs and criticisms of a comparatively small group of little men—little men whose lust for power is far out of proportion to their intellectual capacity, their spiritual understanding, their economic realism and their political honesty. These men of little faith in the American people propose to place all our people—doctors and patients alike—under a shabby, government-dictated medical system which they call compulsory health insurance. And this, factually, is socialized medicine, regardless of how hard they try to disclaim it.

But it is not just socialized medicine which they seek; that is only their first goal. Their real objective is to gain control over all fields of human endeavor. Their real objective is to strip the American people of self determination and self

* President's address before the Ninety-Ninth Session of the American Medical Association, San Francisco, June 27, 1950.

government and make this a socialist state in the pathetic pattern of the socially and economically bankrupt nations of Europe which we, the American people, are seeking to rescue from poverty and oppression.

This we must all recognize: There is only one essential difference between socialism and communism. Under state socialism human liberty and human dignity die a little more slowly, but they die just as surely! Never will our people accept the socialist program that grasping men in our government have planned for them, if they once understand that fundamental fact. And tonight I call on every doctor in the United States, no matter how heavy the burden of his practice may be, to dedicate himself not only to the protection of the people's physical health but also to the protection of our American way of life, which is the foundation of our economic health and our political freedom. The moral and spiritual health of a people certainly is of equal importance with their physical well-being.

It is not American medicine which has failed to measure up to its obligations. It is not American business nor American agriculture which has failed, nor the fine, loyal working people of America who have failed. It is the administrative arm of our government in Washington which has failed us in this generation—a government which is sick with intellectual dishonesty, with avarice, with moral laxity and with reckless excesses. That condition we simply must change, if we are to survive as a strong, free people, and all of us—every one listening to me tonight, regardless of what his way of life may be—must share the responsibility. There are many who recognize this need.

Only two days ago newspaper publishers of the National Editorial Association, which represents 5,200 country newspapers in every section of America, made a pilgrimage to Plymouth Rock to rededicate themselves to the principles and the ideals on which this country was founded and to consecrate themselves anew to the fundamental freedoms of our America. Tonight, in behalf of American medicine, I want to pay tribute to the American press for its staunch devotion to the welfare of our people.

If it were not for leadership of the American press in defending our fundamental liberties, American medicine, even now, might be socialized—and under the heel of political dictation. The newspapers of America, with comparatively few exceptions, have taken a strong stand not only against socialized medicine but against all forms of state socialism in this country—and the doctors of America are proud to take their stand beside the fighting editors of America in the battle to save our freedom and the system of individual initiative which maintains it.

I am taking office as president of the American Medical Association at the halfway mark of the fabulous twentieth century—and I want to review briefly some of the advances we have made before turning to the goals which lie ahead.

The history of American medicine is a vibrant, continuing story of human progress. Because of that progress, millions of Americans are alive today who otherwise would have died at birth, during infancy, in childhood, in youth or in middle age. The story of never ending medical progress in this country is not just a story of so-called miracle drugs and miracle discoveries. The real miracle of American medical progress is the miracle of America itself—the motivating power of the American spirit, of free men, unshackled and unfettered, with freedom to think, to create, to cross new frontiers. Part of the great miracle that is America is our freedom to share, to cooperate, to work together for the common good.

That is the spirit which not only has provided the motive power for American medicine but which has permeated the entire fabric of our American life—inspiring labor and business and industry, science and education and all our fields of endeavor. It is only the course of wisdom and common sense, therefore, to examine the past, present and future of our medical system—to appraise what has been done, what is being done, and what can be done.

For if government—under the guise of misleading promises of health "security"—finally regiments physicians, dentists, nurses, druggists, scientists, hospitals, medical schools and patients under a totalitarian plan which Washington directs and the people pay for, the spirit of individual initiative will be killed not only in the realm of health; gradually, it will die in all phases of American life, just as it is dying today in other nations which first embarked on socialized medicine and then took the final, irrevocable steps down the path of state socialism.

Let us look at the facts:

In America, since the turn of the century the death rate has been cut almost in half. In 1900 the average life expectancy at birth was only 49 years. Today newborn babies have a life expectancy of more than 68 years—a gain of 19 years. For American mothers and babies, the risks of childbirth have been greatly reduced. Both the maternal and infant mortality rates are the lowest in our history. The death rate for mothers in this country is the lowest reported by any nation in the world. I wonder whether the politicians who want control over medicine can point to any comparable achievement.

At the turn of the century pneumonia and influenza, taken together, and tuberculosis were far out ahead as the leading causes of death. Today they have been pushed down to sixth and seventh places, respectively, with death rates less than one-fifth and one-sixth of what they were in 1900.

If our would-be overseers in Washington had made similar progress in the art of government, we might look on their pretensions in the field of health with less fear of the consequences!

Dread diseases like typhoid, diphtheria and smallpox—which 50 years ago took a heavy toll in sickness and death—virtually have been eliminated as national health problems, and all the infectious diseases have been brought under effective methods of prevention, control and treatment.

The fight against disease and premature death is of significance and dramatic interest to every man, woman and child in our country. It is being waged today with weapons which were largely unknown or undeveloped in 1900—new and revolutionary methods of examination, diagnosis and treatment; new drugs, new anesthetics, new surgical technics, new vaccines and serums, new facts about nutrition, new kinds of equipment and facilities, new methods of sanitation, public hygiene and medical education. A vital part of the great advance has been the continual expansion and improvement of our hospital system and the constant raising of standards in our medical schools. Yet only recently the advocates of a government-controlled medical system had the amazing effrontery to castigate American medicine because, they asserted, there were more schools of medicine in 1900 than there are today.

The truth is that in 1900 the American landscape was dotted with scores of unaccredited, second and third rate medical schools, many of which were actually diploma mills for the production of quack doctors.

Is that the condition to which these political medicine men would have us return?

Today, as a result of the American Medical Association's fight for higher standards, that dangerously deplorable situation has been eradicated—and we now have 79 class A medical schools with approximately 25,000 students. And the number of doctors in America is increasing at a more rapid rate than the general population.

The misleading propaganda which has emanated from Washington on this issue is an affront to the American people's intelligence. Typical of this flagrant misrepresentation is the attempt to create a crisis over an alleged doctor shortage in this country. The simple truth is that the ratio of doctors to population is higher in the United States than in any nation on earth except Israel, where the unfortunate refugee doctors of all Europe are gathered. It is equally true, as we are confident most of the people are aware, that the individual physician today can provide far more medical service than even a decade ago, because of technologic improvements.

Now let us look at a half-century of progress in the hospital field:

In 1900, there were less than 1,000 approved hospitals, with approximately 400,000 beds.

Today there are more than 6,300 registered hospitals, with almost 1,500,000 beds, serving more than 16,000,000 patients a year. And the number of hospitals also is increasing steadily.

Finally, in the field of medical economics, the past 20 years have given our nation the new instrument of voluntary health insurance to provide people with prepaid medical care and thereby take the economic shock out of illness.

Today hundreds of excellent voluntary health insurance plans are available. There are nonprofit plans sponsored by doctors and hospitals. There are commercial plans offered by insurance companies. There are fraternal group plans, labor-sponsored plans and industry-sponsored plans.

This has been one of the great advances in medicine in our times, because it is increasing the availability of medical care to people in all income groups.

Compulsory health insurance is not the answer to this problem. The voluntary way is the American way to cope with the problem—and the people, by their support of the voluntary systems, are demonstrating that fact.

In 1946 there were 40 million Americans enrolled in the voluntary health insurance plans. In 1949 the number had increased to 61 million, and now it is approximately 70 million.

Within the next three years, in the opinion of leading medical economists, 90 million persons will be enrolled in our voluntary prepaid medical plans and, when that number has been reached, the problem will have been largely resolved.

This, then, is a brief, overall picture of just one chapter of American accomplishment—the stimulating, hopeful march of medical progress in the past half-century.

Mindful of that astounding progress, we can look forward to even more amazing medical progress in the next half-century, if the American spirit of freedom, initiative and adventure is kept alive.

The doctors believe solutions to current problems of medical care and service can be solved without recourse to legislation, without compulsory payroll taxes and without political pressure.

In the half-century ahead I think we can expect that doctors and their scientific allies will achieve victory over cancer.

I think we will conquer infantile paralysis, arthritis, rheumatic fever, premature heart disease and high blood pressure.

It is reasonable to expect that pneumonia, influenza, tuberculosis, the common cold and other infectious conditions will be reduced to an absolute minimum by new methods of prevention, control and treatment.

And the years ahead will bring a wealth of new knowledge concerning the human mind as well as the human body.

We are on the threshold of great progress which will do much to alleviate human suffering and to prolong human life. But if we are to achieve this maximum progress in the future, we must keep alive the American spirit and the American methods which have made possible the progress of the past and present.

This is the spirit, and these are the very methods which government domination of medical practice would destroy.

In behalf of American medicine, I want to express my deep appreciation of the wonderful support the medical profession has received from civic groups all over America in its fight for liberty.

Nearly 10,000 national, state and local organizations, with many millions of members, have taken positive action against socialized medicine, and there is a rapidly broadening front against all forms of state socialism as a result of the fight that American medicine has been making.

We are proud to have such outstanding organizations as the American Farm Bureau Federation, the American Legion, the National Grange, the Veterans of Foreign Wars, the General Federation of Women's Clubs, the American Bar Association, the American Council of Christian Churches and thousands of other groups standing beside us in this battle for good medicine and sound Americanism.

With the help of God and the American people, the medical profession will continue to minister to the sick, to relieve human suffering and to uphold the ideals which have made America the hope of freedom-loving people everywhere.

MASS CASUALTIES*

Rear Admiral Morton D. Willcutts, MC, U. S. Navy

NATIONAL NAVAL MEDICAL CENTER

BETHESDA, MARYLAND

TODAY ALL branches of medicine, the great civil institutions, clinical and teaching, the private practitioner, as well as we of the federal services, face serious problems incident to postwar readjustments, and to the social economical trends stemming from the "Fair Deal" advocated by President Truman. To these problems of national health and medical economics, the potentialities of another world war must be added. The threat to civil defense becomes ghastly when one considers the deadly menace of special weapons now perfected to produce mass killing and destruction.

We of the Naval Service are wont to think of our careers as prewar, wartime and postwar types of service. Will somebody please define for me just when postwar becomes prewar? Hostilities ceased almost five years ago and yet today the whole world is seething with unrest, searching for a postwar stable peace. Across both the Atlantic and Pacific Oceans the existing unstable postwar conditions threaten the peace of the world.

It is not my purpose, intention or desire to bring to you—my home state—a picture of terror or impending doom. I do wish to warn and to stress that mass civilian casualties may well exceed military deaths in the next world war.

Gone forever are the days of heroic chivalry, when battles were fought gallantly and were confined to orthodox combat zones. Today we face atomic energy and specialized weapons that are perfected for mass killing and widespread destruction of our cities, industries, and treasures.

Battles have been cruel always, but in the early days of history the weapons were simple, side arms, which permitted heroic acts of individual courage and gallantry.

Gunfire, sharpshooting and individual accuracy, has been the fame of our soldiers since the birth of our nation. In the Revolutionary War, disciplined and well-trained British armies were defeated by American riflemen, ragged and hungry, but able to shoot the left eye out of a squirrel. Those were the days of gallantry and individual combat. Now we face total war with casualties no

* Presented at the Alumni Day program at the Indiana University School of Medicine, in Indianapolis, on May 10, 1950.

longer confined to the battlefields, to the ships, and to the armed uniformed services. Tragically, in the future the civilian population, the aged, women, and children, will be exposed to greater losses than a disciplined armed force.

Truly we and the common people of all countries want peace, but I wonder if we are approaching the limit beyond which people's patience cannot endure. Our American way of life, our standards of religion, culture, private property, good living, and comfort are precious and are treasured by most of us. I wish I might say all. But there are those who greedily are envious, and by intrigue, overtly or clandestinely, would distribute and socialize all private property, thus making of our state a communistic order. Definitely the ugly forces of communism are cunning; halted perhaps in Europe they invade Asia, overrun China, and by infiltration threaten all democracies.

Today we face the dilemma of having won a hard and tragic war under the severe terms of unconditional surrender, yet the peace is still unsecured. Wars, hot or cold, are costly and result in great waste of life and material wealth.

A review of the increasing casualties incident to the battles of the world history is startling, amazing and terrifying. The cost to the victor, based on the individual killed enemy, rises sharply. It cost Caesar and his sturdy Roman Legionnaires 50c to kill an enemy soldier. Despite the magnificent generalship of Napoleon the cost to France was $3,000 per dead. For each Confederate soldier killed or dying of wounds the cost to the Union approached $5,000. World War I cost the United States $20,000 per German dead. In World War II the cost for each dead German and Japanese exceeded $200,000. Today the prohibitive expense of total war is so costly that no great power nor the United States may be able to afford it without a resulting complete economic collapse.

You well know that it is natural for men to quarrel, yes, fight. Nations constitute merely the grouping of individuals. Bear in mind that our great nation is a democracy whose very Constitution denies us the opportunity for initial surprise attack such as that so treacherously delivered against us at Pearl Harbor. Though our nation will be subjected again to the first blow, definitely we will not turn the second cheek. It will mean an all-out national effort for an effective retaliating blow and then decisive punches to gain the earliest possible victory. Physical standards for recruitment and drafting will be lowered, for every ounce of manpower will be necessary. Selective Service rejections for the Navy and Marine Corps in the last war at times exceeded 35 percent. That will not do. Those with chronic disorders, even the psychiatric type, will have to find their stride and fight or work. We may well turn to the Emperor Haile Selassie and invoke his order for mobilization. This is true—may I quote:

"Everyone will be mobilized and all boys old enough to carry a spear will be sent to Addis Ababa. Married men will take their wives to carry food and to cook. Those without wives will take any women without husbands. Women with small babies need not go. The blind, those who cannot walk, or for any reason cannot carry a spear, are exempt. Anyone found at home after receipt of this order will be hanged."

A goodly portion of our Indiana alumni are veterans of both World Wars I and II. We all are alert to the new fields of intensive warfare, to the special weapons designed for mass killing and destruction that were introduced during the closing days of Japanese hostilities. Vivid is your memory of the single bomb destruction of Hiroshima and Nagasaki. You know well the terrible effectiveness of the atomic bomb of the vintage of 1945. That bomb and later developments gave us a great sense of security for here was a most efficient weapon capable of releasing deadly forces, bizarre, fearful and startling in type, lethal forces related to the peculiar radioactive characteristics of nuclear fission products—the alpha particle, the beta particle, the neutron and the gamma ray, supplementing the terrific explosive blast and generated heat of the bomb.

Last September came the startling announcement of President Truman—the explosion of an atomic bomb by a great foreign nation (Russia). Our dilemma becomes intense, for gravely a great scientist has warned that in point of awesome potentialities the only thing worse that could happen to a single nation in possession of the atomic bomb is for a second nation to achieve such a weapon.

The potentialities of an even greater weapon, the Hydrogen bomb, is currently widely publicized. Official discussion on this subject was sharply restricted following the grave Presidential announcement that construction of the Hydrogen bomb was being authorized (January 31, 1950).

You have or will see our film "The Tale of Two Cities," Hiroshima and Nagasaki. As fleet Surgeon, my Naval duties carried me to both cities during the month following their destruction. Words are inadequate to describe the silent, ghostly horror of those devastated and deserted cities.

Then came Bikini and Eniwetok, postwar experiments with the atom bomb that have proven beyond doubt the target blast forces and what may be expected by the unleashing of deadly atomic energy. The medical aspects of these forces have been carefully checked and are under constant review at our Naval Medical Research Institute, a component part of our National Naval Medical Center at Bethesda.

I stress that in searching for peace the world is rearming with deadly weapons specialized and perfected for mass killing and destruction. The medi-

cal aspects of the atomic bomb are terrible and may not be overemphasized.

Representative Carl Vinson of Georgia, Chairman of the House Armed Services Committee, addressed the Congress in a critical review of the National Defense budget last month (April 4, 1950). I quote his concluding statement:

"Gentlemen, the atomic blitz of tomorrow is a real, a genuine possibility. We have no alternative but to prepare today for meeting it tomorrow, because tomorrow our preparations may well be far too late."

Now there are those, a great number, who believe that such a terrible weapon as the atomic bomb should and must be outlawed by international agreement. You are all aware of our nation's proposals and sincere desire to achieve this goal. It is tragic that international accord and agreement appears so indefinite and uncertain.

There are those, a great number, who doubt that the outlawing of any efficient weapon would prove a sound security measure. They believe that a ruthless leader would use the atomic bomb or that a desperate enemy driven to cover would employ any agent that might turn the tide of defeat into victory and conquest. Biological warfare must be considered. I will refer to the potentialities of radiological and biological warfare later.

So we must accept the cold terrible facts. We must appraise and estimate the situation on the premise that our great country, our harbors, cities, industries, and treasures will be subjected to an atomic bomb blitz. The immediate concern is, of course, mass casualties, the killing and maiming of countless thousands of our people.

I shut my eyes to Hiroshima and Nagasaki. You all have heard detailed reports of their destruction. That was war, but fought on the opposite side of the world. All right, let's come home and review the tragic fate of Texas City when a burning ship exploded at the pier: six hundred fifty-two killed, thousands wounded, damage claims approaching two hundred million dollars. May I read a personal message to me, coupled with extracts from the official report of Dr. Clarence F. Quinn, medical coordinator to the Honorable Mayor and the City Commissioners of Texas City, on that fateful day. I quote:

"On the morning of April 16, 1947, I was making my house calls. I was in the suburbs two miles away from the explosion. I am glad I was not sitting at my desk because I wouldn't be here today. I saw lots of gunfire overseas and got wounded in a mess of it, but believe me it was nothing like what happened that day in April. When I got hit on the Moselle during the war I thought it was bad, but this was worse. Although I was two miles away on this day of the explosion I thought I was again under artillery fire, and my first thought was to hit the deck, and quickly. The house shook and came near coming down on my ears. I left my patient with the remark 'Just keep taking the same medicine.' I rushed back towards the pier. I can still see those people standing beside the road as I sped past with horn blowing and hitting 80 miles per hour on the speedometer. They knew in their hearts that their fathers and brothers and husbands were down there and they knew that they were dead. I knew it too, but I didn't know how many were there and how many were dead and how many were mangled . . . . Fire had broken out on the freighter 'Grand Camp' shortly after 8:00 o'clock that morning, and many sightseers were in the immediate vicinity when the terrific explosion occurred at 9:12 a.m. Hundreds were killed and mangled at the pier. Hundreds more living at great distances from the site of the explosion sustained fatal and serious injuries by flying debris and falling buildings . . . . As the tragic blast rent the air all doctors immediately returned to their respective clinics and prepared themselves for the influx of casualties which they knew would be forthcoming . . . . They came on foot, in trucks, private cars and trailers. The facilities of all clinics were soon overtaxed and doctors found themselves unable to give definitive treatment and could only treat shock, give morphine, and minimum first aid. After the blast we were without water and electricity. We were unable to wash wounds or even utilize electric lights for careful checking of the injured. Our x-ray machines were valueless. Our clinics overflowed and we found ourselves on the outside of our offices directing the outdoor installation of cots, warm clothing, and so forth.

"We waited for ambulances. None came. We learned that the ambulance drivers were dead, that the ambulances had been blasted. They were at the scene of the explosion and had been blown into bits. We resorted to commandeering all buses, trucks and cars. As they brought patients to us we reloaded them for deliveries to outside hospitals and neighboring towns . . . . I kept waiting for burn cases to arrive. None came, for actually, with less than 10 exceptions, all the patients who were severely burned were dead before any help could reach them . . . .

"Much credit must be given the people in hospitals of Galveston, John Sealy, St. Mary's, the Marine hospital, and at Fort Crockett. Medical students of the University of Texas were a great help in relieving our exhausted group of Texas City doctors. Great credit is due alert Galveston citizens who organized a patrol along the highways entering Galveston in order to expedite delivery of patients to the hospitals in the minimum length of time. It is recorded that vehicles carrying injured attained speeds of 80 miles per hour without fear of cross traffic.

"Great credit is due our police and firemen, and to the doctors of the Mainland who treated the

overflow of patients unable to receive attention at our crowded clinics . . . .

"The assistance given by the Army and Navy is recounted in separate reports, but it is proper to state that the Navy had trained personnel at the scene within a few hours, under direct orders from the Navy Department. The Army and Navy gave freely of blankets, bandages, gauze, and drugs. No property responsibility was attempted and the articles were freely disbursed . . . .

"The Salvation Army came upon the scene and undertook their program of relief. On reaching the scene of the disaster the American Red Cross organized their program. Our task could never have been handled without their well planned assistance.

"Although not a medical issue in the strict sense of the word, the work of the undertakers and embalmers of our dead must not be overlooked. Our dentists were of great assistance in identifying the dead through teeth examinations. We suffered a devastating blow, but with God's assistance and the charity of our fellow Americans we are rehabilitating our wounded. Our dead have been buried. Our widows and orphans have reconciled themselves to their loss in the words, 'Not my will, Oh, Lord, but Thine be done.'

"Our thanks to the people of the United States for their wonderful assistance in providing funds and medical supplies. Without their help we could not have taken care of our gigantic problem."

The above is an eyewitness account of a terrible catastrophe. However, the havoc resulted from conventional power and was not atomic. Multiply that scene at Texas City from one hundred to one thousand times and you have the chaotic conditions resulting from atomic war. (The dead at Hiroshima and Nagasaki exceeded one hundred thousand, with nearly as many more injured.) Add to these conditions the hazards of radioactivity, the lightning-like lethal atomic fission products—the gamma ray, the neutron, the alpha and beta particles, and you have the complete picture of modern total war.

Add to this an intelligent appraisal of these deadly and bizarre atomic rays and you have the basic knowledge and foundation necessary for an effective American community defense and for the management of mass casualties.

There is a defense. At the Naval Medical Center in Bethesda we have been conducting a series of courses on the "Medical Aspects of Special Weapons and Radioactive Isotopes." At the conclusion of these lectures our Reserve Medical Officers have told me repeatedly, "Many of us came disheartened and with a helpless attitude on the atomic bomb. The casualties were just too staggering. The course has dispelled this defeatist attitude."

I repeat, there is a defense. We do not need to hide or to become frightened out of our wits into hysteria. Forewarned is to be forearmed. There is protection against the deadly atomic rays. Our scientists know well the limitation of the furious power of the bomb, the effects of an atomic explosion upon people, the medical and the biological aspects of injuries and their treatment.

We know that rescue work may and should start at once, that within a matter of minutes, I might say 90 seconds, the powerful gamma and neutron rays, having killed or stricken those within range, are dispersed into the skies. In an atomic bomb air blast, for all practical rescue work, the situation becomes rapidly conventional. It will be relatively safe for you to enter into the devastated areas under precautionary measures—this within a very brief time, emergency time vital for the evacuation and care of those who would otherwise burn to death or die of untreated wounds.

In the air blast attack on Hiroshima and Nagasaki there was little or no residual radioactivity chargeable to the alpha and beta particles. At Hiroshima I was impressed by the absence of a crater, even at the very heart of the explosion. I recall the intact streetcar lines, straight and true, glistening like steel ribbons beneath the ashes and debris. There was no dangerous amount of radioactivity on the ground, although our Geiger counter did register feeble warnings. It is proven that the alpha and beta particles are emitters having little or no penetrating power; that one must inhale, swallow or absorb them into an open wound.

This afternoon we cannot go into detail. However, I do wish so much to emphasize the cardinal facts—that for all practical purposes radiation injuries, fatal or serious, from the nuclear radiation of an air-burst atomic explosion are due mainly to the neutrons and to the gamma rays. This is external radiation, the instant release of atomic energy from the explosion of the bomb.

The neutrons are tiny invisible particles driven out of fissioning atoms. The gamma rays are invisible electromagnetic waves very similar to powerful x-rays. These constitute the greatest immediate radiological danger in an atomic blast. They may kill instantly if exposure is within a radius of a mile. From one and one-half miles to two miles their dilution becomes so rapid that serious injury may not occur. Without pain or sensation, chemical and physiological changes occur in the body cells. If the ray dose is sublethal, symptoms may not appear for several days. These victims will not require first aid treatment, and being on site they themselves may render valuable assistance to the injured.

The alpha particles are positively charged helium nuclei and have ionizing power ten thousand times that of the gamma ray. The alpha particle is stopped, however, by an inch or two of

air, by a sheet of paper, or by the surface layer of the skin, which it affects very much like a burn.

Beta particles are negatively charged electrons and have one hundred times the ionizing power of the gamma ray. They travel only a few yards through the air and can be stopped by a sheet of paper or by clothing, but may penetrate about one-fifth of an inch into the skin, producing a burn-like lesion.

For practical purposes atomic radiation may be considered as external or internal. External radiation is due to the striking gamma and neutron rays. Internal radiation comes from the alpha and beta particles or radioactive isotopes introduced into the body. Therefore, the effects of external radiation of the alpha particle is zero; beta, one plus; neutron, four plus; and the gamma, four plus. The reverse is true of internal radiation, the particles having been inhaled, swallowed, or absorbed through open wounds—alpha, four plus; beta, four plus; neutron, one plus; and gamma, zero.

Now we know that the bomb may be exploded in the air at high or low altitudes, under water. or ground. The resulting hazards from the explosion will vary greatly, depending upon where it is detonated. At Hiroshima and Nagasaki 85 percent died from blast injuries and burns, while the remaining 15 percent died from external radiation, the effects of the gamma and neutron rays.

Hazards in the case of underwater or ground explosion remain to be evaluated, but it is known that blast injuries and burns would be decreased, that prompt radiation would be markedly reduced, but that residual radiation hazards would increase and be prolonged due to heavy contamination of adjacent grounds, water, buildings, and so forth.

Material damage would also be affected by the method in which the bomb is employed. On a score of four: air burst blast—buildings destroyed four plus, fires four plus, transportation four plus, communications four plus; underwater and ground burst—buildings destroyed two plus, fires two plus, transportation two plus, communications two plus.

It is plausible to consider that an inland city such as Indianapolis would be attacked from the air, and that the bomb would be delivered as an air blast about two thousand feet above the Soldiers and Sailors Monument.

Within an instant, without pain or sensation, exposed people within one thousand yards from the Monument will die from external radiation, the gamma and neutron rays. This will be about 15 percent of the total killed. Many thousands, the remaining 85 percent, will die primarily of blast injuries and burns. Serious injury will occur to people for a distance of two miles from the Monument, with total destruction or serious damage to all buildings within this zone. Decreasing casualties and damage will occur as far out as four miles. The total killed and injured may well approach the figures of Hiroshima and Nagasaki—one hundred thousand dead, another one hundred thousand injured.

The primary blast force will tear and disrupt ear drums, sinuses, lungs, stomachs, intestines, and kidneys, or death may result more indirectly from the tornado-like collapse of the buildings and by the missile effect of flying debris. The burns may be flash from the radiant heat or be produced by flames from fire breaking out in the wreckage.

The radiant heat may be expected to produce fatal or third degree burns within a radius of 1,500 yards and second degree burns up to 2,500 yards. These burns are instantaneous.

The shock wave from the blast will sweep out rapidly from above the Monument. In the case of Hiroshima, it is estimated that it took ten seconds for the blast wave to travel two miles to the perimeter of greatest damage.

The magnitude of the above casualties appears almost hopeless, for here at Indianapolis most of your doctors and trained medical personnel, as well as your hospitals and dispensaries, would be wiped out or be too disabled for functional use. Those surviving the immediate blast and the radiation must be rescued promptly, or they will perish in the resulting fires. I cannot overstress that in such a type of air burst rescue work may begin promptly, for the radiation hazards will diminish rapidly. With attention and respect for the alpha and beta particles, no great amount anticipated, devastated Indianapolis may be entered.

Our scientists and medical officers believe that it would be unrealistic to prepare for fewer than 40 to 50 thousand severely burned cases from a single atomic bomb explosion. You all know the tanks of oxygen, the constant nursing, the yards upon yards of gauze, and the important need of plasma and whole blood, plus morphine and the antibiotics necessary to treat a single severe burn case.

Injuries of every description will be present—fractures, hemorrhage, open wounds involving all the body cavities. Definitive, on-site treatment will be simply impossible. Fortunately, severe symptoms from the atomic rays of those not killed outright will be delayed several days. The management of mass casualties thus may be limited to those suffering from blast injuries and from flash and flame burns.

The medical aspects of the atomic bomb and the management of mass casualties have been presented in summary and you have been briefed on the main factors. I have stressed that the main problems will be the care of blast and burn injuries and in numbers that will swamp normally available facilities.

Atomic warfare is now definitely a two-way possibility. No local community may feel secure

by mere isolation. Every state and county must be on guard. In attendance at our great medical conventions I have been impressed by the apparent apathy relating to mass casualties. The clinical programs, research, medical, and surgical, are excellent but, from the angle of modern warfare, may well have been prepared in the "Gay Nineties," inasmuch as the addresses usually relate to the care and management of the individual patient; seldom, if ever, to great disasters. Should there be a next time—a third world war—effective civilian defense will require an ultimatum similar to that of the Emperor Haile Selassie.

Civilian defense will require more than victory gardens, rubber and tin can salvage. Trained neighborhood wardens, at least two to a block, will be necessary. Every man, woman and child will have an active part to play, beginning at the home, the neighborhood, the precinct, the ward, township, city and county units.

The individual specially trained in emergency procedures will do all he can to help himself. The family, working as a unit, will endeavor to protect its own home and those of its neighbors. The community, with its emergency protective force fully organized and coordinated, will strive to maintain or restore those services and facilities essential to civilian life and to the continuation of industrial production. Should local defensive efforts prove inadequate—and they will, when you consider the total disruption of communications, transportation, and utilities—then of course aid must come from nearby communities. Fire will again be the great destroyer. We have in our nation sixteen thousand organized fire departments, backed up by police and special rescue squads.[1] These must serve as the backbone of our front line of civil defenses. The second line for defense will be built around the medical services. The health measures to prevent diseases and to control sanitation will be vital and exacting.

The care of the dead—thousands upon thousands —will be awesome. Our medical schools, our doctors and dentists, and all other medical scientists, have a major obligation in helping to teach our vast public the true hazards of atomic warfare. They must help to drive home the fact that blast and heat are by far the bomb's most effective forces. The public must be informed as to the practical danger, instant and latent, of the atomic rays. It is the fear of the unknown which destroys reason and which will lead to delay in rescue work, thereby permitting many, many more to die.

Early and unofficial reports following Hiroshima, Nagasaki and Bikini were inaccurate and excited too much respect and fear of the radiation hazards in the wake of an atomic explosion. The effects, instant and secondary, of exposure to the atomic rays, were overemphasized and led to many distorted reports widely publicized.

The genetic effects produced grave concern. The Atomic Bomb Casualty Committee in Japan has dealt with the possible effects of massive radiation doses on human heredity. The genetic effects among the Japanese at Hiroshima and Nagasaki will show up in the offspring of the exposed people, though possibly not until the second and subsequent generations. No such effects have been observed up to this time. The Commission states that perhaps twenty-five more years must elapse before reliable information can be obtained about the effects of atomic radiation exposure upon heredity.

The Commision also made a survey dealing with the sterility of the Japanese surviving the atomic bomb radiation blast. It is known that ionizing radiation can cause permanent sterility but the dose required is about 400 roentgens, which is the range of the median lethal dose. Temporary sterility occurred among many Japanese, both male and female, but the vast majority of them had returned to normal within a year or so. Many have produced normal children since their illness.

I have spoken darkly. One must extrapolate to reach a realistic estimate of the killed and wounded occurring from an atomic bomb, the blasting of our great industrial centers—our own Indianapolis. The picture is simply ghastly.

So much, or in perhaps better speech, so little for the atomic bomb. Just recently the severe restrictions guarding our knowledge of radiological warfare and the ultrasecret biological agents have been liberalized.

The Department of Defense now advocates wide publicity and the withholding only of that information which might jeopardize the national security or disclose critical military secrets.

These highly specialized agents, the mysterious RW and BW weapons, may now be discussed openly so that the American people may be briefed on the nature and scope of offensive and defensive radiological and biological warfare.

Here we have another venture into the field of mass casualties, the disabling and the killing of civilian as well as military personnel.

These new agents, however, attack only the animal and plant kingdoms, men, domestic animals, crop plants and forests. Their mission is mass sickness, even death. They do possess one redeeming feature—they do not destroy buildings nor do they create devastating material losses incident to fire and blast. The spoils of conquest are left intact for the enrichment of the victor.

Radiological warfare is another outgrowth of atomic energy, the fission products, nonexplosive but radioactive, with "decay" age at a known rate spoken of in terms of its half-life, and ranging

[1] Richard Gerstell, Ph.D., "Disaster Planning," National Naval Medical Center, Bethesda, Md.

from seconds to thousands of years. These particles are emitters of the four types of ionizing radiation previously discussed in this paper; namely, the neutrons, alpha particles, beta particles, and the gamma rays.

The objective of this form of warfare would be to make a given area untenable through the presence of radioactive particles called RW agents. The existence of radioactive materials and the possibility of producing them artificially have been known for some time. However, only with the development of the nuclear reactor, in 1942, did it become possible to produce these agents in sufficient quantities for military consideration. Please note that every atomic pile of suitable size, irrespective of its design or purpose, is a source of significant quantities of RW agents. Thus RW weapons could become available to other countries whether or not they produced an atomic bomb.

Due to its unique nature, radiological warfare carries many indirect advantages and disadvantages. These are being evaluated and carefully appraised, I assure you.

Biological warfare is the employment of certain disease agents, infectious for man, domestic animals, and crop plants.

Although the potentialities are very great, biological warfare should not be considered a means of mass destruction comparable to atomic warfare. Because most BW agents consist of living matter they are very susceptible to destruction by heat and other environmental factors. Special means for handling and distributing those agents are under study, and current research indicates that many of the limiting factors can be overcome.

The efficiency of BW agents in comparison with other means of warfare cannot be known short of actual use, but when all factors are considered, including the psychological, it must be assumed that attacks with BW agents could be very effective.

The BW agents are peculiarly suited for use in sabotage. Minute amounts of active materials are sufficient to produce considerable damage. The effects of sabotage may be delayed, often for days, since diseases do not manifest themselves immediately. Death or disease caused by sabotage with BW agents might even appear to be from natural causes.

Decontamination against BW agents presents serious problems, many of which have not been solved. The best protection would be provided by alert and strong public health and agricultural services.

Protection against anti-personnel and anti-animal BW agents will consist of: (a) biological measures (vaccines, drugs, etc.); (b) physical measures (masks, clothing, shelters, decontaminates, etc.); and (c) organizational measures (sanitary, public health, etc.). Protection against the effects of anti-crop agents will consist of intensification in the breeding of resistant plant varieties, plant quarantine and inspection, plus the usual agricultural disease control measures.[2]

Thus the potentialities of radiological and biological warfare in the production of mass casualties are truly fantastic and intriguing. We must not, however, permit them to become mystery weapons with a build-up of psychological propaganda leading to hysteria.

Again and again we must drive home that there is a defense against these new and terrible weapons of total war. We need not hide.

We will survive. Our country is young and very, very strong when angered or attacked. I like a recent statement by Vice Admiral Berkey, our new Navy Chief of Information: "America has often been flouted and derided — sometimes pushed around. We have been difficult to anger and slow to retaliate, but through the generations of our existence as a peace-loving democracy we have formed one excellent habit—we win wars."

[2] Semiannual Report of the Secretary of Defense, United States Government Printing Office, Washington, 1950.

EIGHT INDIANA SOLONS VOTE AGAINST REORGANIZATION PLAN

In what was interpreted by many Washington observers as a test vote on socialized medicine, the U. S. House of Representatives overwhelmingly defeated Reorganization Plan No. 27, which would have created a Department of Health, Education and Security, supposedly with Oscar R. Ewing as its head.

Eight Hoosier congressmen voted against the President's recommendation: Charles A. Halleck, Republican; Thurman C. Crook, Democrat; Edward H. Kruse, Jr., Democrat; Mrs. Cecil M. Harden, Republican (paired); James E. Noland, Democrat; Earl Wilson, Republican; Ralph Harvey, Republican; and Andrew Jacobs, Democrat.

Three Indiana congressmen voted for the plan: Ray J. Madden, Winfield K. Denton, and John R. Walsh, all Democrats. Newspapers erroneously reported Mr. Walsh as not voting, but the House roll call reveals him as voting "Yes."

AMERICAN MEDICAL ASSOCIATION

THE 99th Annual Session of the A.M.A. attracted record-breaking crowds to its five-day program at San Francisco, June 26 to 30. It was preceded by meetings of thirty-odd specialty societies during the week previous, and on Sunday by the National Conference of County Medical Society Officers, and the Conference of Presidents and Other Officers of State Medical Associations.

Indiana was represented by a registered delegation of 118. Total registration from United States and foreign countries was 23,655. This included 10,119 physicians, and 13,536 exhibitors and guests.

The Conference of County Medical Society Officers met on Sunday morning, with Dr. A. M. Mitchell of Terre Haute as chairman. The program presented an interesting and worth-while discussion of the mechanics of conducting the affairs of a medical society. Information on socialized medicine and a discussion of medicine's relation to allied groups rounded out the program. Doctor Mitchell was honored by being reelected to the chairmanship of the Conference.

The Conference of Presidents and Other Officers of State Medical Associations was highlighted by an address by Mr. Harry Becker of Detroit. Mr. Becker is the Director of the Social Security Department, United Automobile-Aircraft-Agricultural Implement Workers of America, CIO. He spoke on the subject "Labor Looks at the Problem of Prepaid Medical Care."

According to Mr. Becker, neither the medical society's sponsored Blue Shield Plans nor the commercial insurance companies provide the type of prepaid medical care coverage desired by organized labor. He also contended that these programs do not meet the American Medical Association's published standard for prepaid medical care plans. In both cases, Mr. Becker said, the coverage was too limited and the operating costs too high.

He felt that consumer-sponsored prepaid plans which utilized local medical groups should prove more effective and less expensive to the worker. Mr. Becker stated that the A.M.A. gave equal support to commercial insurance plans and Blue Shield plans but did not encourage consumer-sponsored prepaid plans. The unions cannot understand the reason for this attitude. He also stated that Labor does not understand the A.M.A.'s failure to cooperate with the Blue Cross hospital service plans.

The Labor Unions want comprehenive coverage for both medical and hospital services for their workers. Mr. Becker thinks that the Blue Shield plans should also raise the income ceilings now in force without raising the premiums, in order that the workers would not be subject to additional charges for medical services.

Mr. Becker also stated that a feeling of distrust of the A.M.A. has grown in the unions due to the A.M.A.'s opposition to the government's proposal for cash disability benefits for sick and injured workers. The unions also question the A.M.A.'s sincerity in improving the public welfare when its National Education Campaign office distributed one and one-half million copies of John T. Flynn's book "The Road Ahead." According to Mr. Becker, that book contains much false and misleading information relative to social welfare programs.

Another speaker on the same program, H. E. Slusher, president of the Missouri Farm Bureau Federation, stated that one and one-half million farm families are beginning to question the wisdom of the government doing everything for them. The rural people, however, need the cooperation of the medical societies in developing their own programs for improved health. In many instances the medical societies' public relations have been bad, and physicians give the impression of holding themselves aloof from the local problems.

The Annual Session itself opened Monday morning with a large and appreciative audience. The program included the incomparable Scientific Exhibit, medical and surgical clinics by colored television, and the general and section meetings of the scientific assembly. All were well attended and most of the gatherings afforded standing room only.

One of the general meetings was a symposium on atomic energy. The leading address was given by Mr. Gordon E. Dean of the U. S. Atomic Energy Commission. Also discussed were the problems of treatment of casualties resulting from atomic explosions, and the peacetime medical uses of radioactive isotopes.

Advances in military medicine and surgery and the military research program were discussed on a program devoted entirely to these subjects in the section on Miscellaneous Topics. As a result of this program and because of the excellent attendance, it is probable that a new section will be created for military medicine.

Outstanding on the program were lectures, symposia, and exhibits on ACTH and cortisone, diabetes, peptic ulceration, antibiotics and fractures. Numerous reports were made to show that the prevention and treatment of common colds by anti-histamines are of no avail. One controlled experiment was reported in which the subjects got better results when receiving the placebo than when receiving anti-histamine.

Hoosier doctors who served as officers of sections were Dr. A. S. Giordano, South Bend, vice-

chairman of the Section on Pathology and Physiology; and Dr. Lester D. Bibler, Indianapolis, vice-chairman of the Section on General Practice.

Participants in the scientific program were:

Dr. Franklin B. Peck, Indianapolis, who presented a paper on "Insulin Mixtures" as a part of the Clinical Conference on Diabetes.

Dr. V. K. Stoelting, Indianapolis, opened the discussion on a paper entitled "Controlled Clinical Evaluation of Three Curare Preparations."

Dr. Herman H. Rodin, South Bend, was coauthor of "Treatment of Psoriasis with Undecylenic Acid by Mouth: A Status Report."

Dr. L. W. Freeman, Indianapolis, opened the discussion on "Management of Residuals of injuries to the Spinal Cord and Cauda Equina."

Dr. L. E. Burney, Indianapolis, was an invited discussant on a "Symposium on Screening Technics for the Discovery of Chronic Diseases in the Adult Population."

Dr. Lester D. Bibler, Indianapolis, was elected chairman of the Section on General Practice for the ensuing year. Dr. John E. Dalton, of Indianapolis, was elected vice-chairman of the Section on Dermatology and Syphilology

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A.M.A. JOURNAL TO BE INCLUDED WITH A.M.A. DUES

William M. Cockrum, M.D.*

EVANSVILLE

DELEGATES of the A.M.A., meeting in the ninety-ninth annual session of the Association in San Francisco last June, accepted the recommendation of the Board of Trustees that members of the A.M.A. receive *The Journal of the A.M.A.* as a part of their dues. This action will become effective January 1, 1951, so all who pay 1951 dues will receive *The Journal* at no extra charge. The subscription price for *The Journal* to nonmembers was set at $15.00 per year.

The House also accepted the recommendation of the Trustees that the dues for 1951 be $25.00, with dues for future years to be set by the House of Delegates during the annual session.

In explaining the request of the Board for establishing the 1951 dues at $25.00, Dr. Louis H. Bauer, chairman of the Board, stated that the expense of operating the Association exceeded the income from A.M.A. publications. Also, the expansion necessary in the various departments of the Association, together with the continuance of the National Educational Campaign, makes it mandatory. Membership records and *Journal* subscription records will be maintained on a calendar year basis.

This action by the House, in including *The Journal* with 1951 dues, was perhaps the most important step taken, as it affects every physician in the United States and the Territorial Possessions.

Meeting in almost continuous session, the House of Delegates had a large audience of interested physicians watching the activities of the great policy-making body of the Association. The Audience observing the actions of the House many times exceeded the 198 Delegates. This, according to officials of the Association, was a healthy sign, as they felt it indicated an increasing interest on the part of the profession in the efforts of the Association to maintain freedom in the practice of medicine.

Adopting a modified version of the Hess report, the House criticised and condemned the practice of hospitals employing physicians on a salary basis for rendering professional service to their patients. The chief provisions contained in the report as adopted call for: 1. It shall be unethical for any doctor to hire out his services to a hospital on a salary basis. 2. Policing power shall be in the hands of component county medical societies. 3. The A.M.A.'s committee on medical education may place on its unapproved list any hospital which continues to hire doctors, thereby depriving that hospital of legitimate interns.

Discussion of the Hess report consumed some two hours on the floor, but the House felt that immediate action should be taken toward implementing the provision of its action. Speaking out in favor of immediate action on the report, one proponent of the report stated, "I think it will bring about a great deal of saving to patients in situations where hospitals have been making a profit on the doctor's services." Another said, "This is a service to the public to avoid hidden

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* Delegate from the Indiana State Medical Association to the House of Delegates of the American Medical Association.

charges in medical bills. We don't want patients paying money for their illnesses and not knowing where it has gone."

The report is aimed at two major evils, according to A.M.A. leaders:

1. Hospitals making a profit out of a doctor's services (i.e. a hospital may charge a patient $100.00 for a given operation, pay the surgeon only $50.00),

2. The practice of medicine by corporations (incorporated hospitals).

The rule will not affect interns who are paid salaries by hospitals while completing their final specialty training, nor will it affect residents.

Practically every activity of the Association came in for its share of attention by the House in the more than 170 pieces of business acted upon. Reports and resolutions adopted call for further expansion of the personnel and services of the Washington office, the Public Relations Department and the Council on Medical Services. Also renewed was the contract of the public relations firm of Whitaker and Baxter for the year ending December 31, 1951. Expansion of these departments was deemed necessary, the Board stated, in order that in the near future more and more of the activities which have been formerly conducted by Whitaker and Baxter may be taken over by these various departments. "We hope to see the day when our victory against government medicine has been made so secure that we, again, can revert to handling all our activities within the confines of our own departments. With this thinking in mind, it is imperative that we begin now to prepare our organization for this responsibility in order that we will be prepared, when the proper time comes," Doctor Bauer stated.

Included in some of the more important actions of the House were: Encouragement of plans for licensing displaced physicians in this country; authorization of a Student Medical Association, calling for the Board of Trustees to initiate the organization of such a body; adoption of the report of the committee on medical education and medical practices in England, these to be published in an early issue of the A.M.A. *Journal;* refusal to support the Association of Interns and Medical Students as presently constituted; criticism of the practice of some hospitals in making specialty board membership a requisite for staff appointment or advancement.

Other actions included were: Recommendation of the establishment of a separate section on Military Medicine and Surgery; approval of the theory of self-testing by individuals for diabetes and the reporting of any abnormalities to their family physician; authorization of an Interim Committee on Constitution and By-Laws, with further discussion to be held at the interim session regarding the establishment of a standing committee on Constitution and By-Laws; approval of the participation of Associate Fellows in the Scientific assembly but without the power of voting; that the standing of Fellowship should be retained, and the matter was referred to the interim committee on Constitution and By-Laws with the request that they make a recommendation at the next session of the House; approval of the action of the Board of Trustees in opposing the Public Health Association's "Blue Print."

Other matters acted upon by the House in the field of Legislation and Public Relations were: Requested that the legislative committee study the advisability of advocating income tax exemption for the cost of Post Graduate courses; reaffirmation of the Association's opposition to House Resolutions 522 and 5940 and Senate Bills 1411 and 1453; the House granted broad powers to the Legislative Committee for action on nonmedical legislation; established a continuing committee to study, make changes and clarify the Association's 12 point program; recommended study aimed at establishing a two-year rotating internship in obstetrics and gynecology.

Actions under the classification of Emergency Medical Services taken by the House included: The adoption of a resolution in which the A.M.A. is to advocate the appointment by the Federal government of a professional medical advisory council to work with the top policy advisory board of the government; adoption of a resolution advocating a Council within the A.M.A. on Federal Medical Services (this was referred to the Board of Trustees for study with the recommendation of the Board to be made at the next session of the House); a resolution calling for the return of medical care of the government's civilian employees to the private practititioner was referred to the Board of Trustees.

Other actions taken by the House classified as Miscellaneous Business were: A resolution calling for a survey of costs of medical care was referred to the Board of Trustees for transmission to the Bureau of Medical Economics Research; endorsement of the World Medical Association; adoption of a resolution calling for clarification of medical ethics; approval was given of a resolution requesting that better planning of meetings be done by A.M.A. to reduce the multiplicity of meetings. It was agreed that collection of A.M.A. dues was possible only through the State and County Medical Societies.

Two actions affecting insurance and medical services were adopted. One recommended that State Medical Societies establish a system of approval of hospital and medical care insurance plans being offered the public of the respective states. The other recommended that insurance companies writing hospital and medical care in-

surance provide payments for the services of graduate nurses as a part of their benefits.

During the opening session of the House, Dr. Everts A. Graham, professor of surgery at Washington School of Medicine and surgeon-in-chief at Barnes Hospital, St. Louis, received the American Medical Association's Distinguished Service Award for 1950.

For the first time in the history of the A.M.A. the inauguration of a president and a session of the House of Delegates were broadcast on a nation-wide radio hook-up. On Tuesday evening, June 27, before a crowd that taxed all the facilities of the Palace Hotel, Dr. Elmer L. Henderson of Louisville, Kentucky, was installed as President of the A.M.A. for the term of 1950-51.

Officers elected during the final session were as follows: John W. Cline, San Francisco, President-elect; R. B. Robbins, Camden, Arkansas, Vice-President; George F. Lull, Chicago, reelected Secretary; J. J. Moore, Chicago, reelected Treasurer; F. F. Borzell, Philadelphia, Speaker of the House of Delegates (reelected); James R. Reuling, Bayside, New York, Vice-Speaker (reelected); and Leonard Larson of Bismarck, North Dakota, and Thomas P. Murdock of Meriden, Connecticut, to the Board of Trustees.

Registration for the 1950 sessions disclose a total of 23,655, the largest of any previous San Francisco meeting. Of this total 10,119 were Fellows and Members.

In selecting the city for the 1950 Clinical Sessions, the House was informed that due to repairs being made in Denver, it would be impossible to hold the December sessions there as planned. Cleveland, Ohio, was then selected as the site of the 1950 Clinical Session, which will be held December 5-8.

Locations of future meetings of the A.M.A. are as follows: 1951 Annual Session, Atlantic City, June 11-15; Interim Session, Houston, Texas. 1952 Annual Session, Chicago; 1953 Annual Session, New York City.

The Indiana delegation introduced two resolutions before the House. One called for the same action contained in the Hess report as was adopted, while the other requested a survey be made to determine the cost of medical care and how it is distributed. This latter resolution was referred to the Board of Trustees for transmission to the Bureau of Medical Economic Research. Dr. F. S. Crockett and Dr. W. M. Cockrum read the resolutions before the House.

Two Indiana physicians were honored by the House, being asked to serve on House Reference Committees. Dr. Homer G. Hamer, Indianapolis, was appointed to the Reference Committee on Emergency Medical Services; and Dr. F. S. Crockett, Lafayette, was appointed to the Reference Committee on Executive Session.

The following Indiana physicians registered at San Francisco:

Ade, Charles H., Lafayette
Ade, Mary Keller, Lafayette
Allen, Robert A., Fort Benjamin Harrison
Anderson, Ralph J., Indianapolis
Arbogast, J. L., Indianapolis

Ball, Clay A., Muncie
Baxter, Neal E., Bloomington
Beeler, Raymond C., Indianapolis
Bender, C. K., Goshen
Bergan, Joseph A., Michigan City
Bibler, Lester D., Indianapolis
Birmingham, P. J., South Bend
Black, Claude S., Warren
Bolka, Bernard J., South Bend
Bond, Walter C., Clay City
Brady, Samuel, Gary
Bunde, Carl A., Indianapolis
Burney, L. E., Indianapolis

Cameron, Don F., Fort Wayne
Casey, Stanley M., Huntington
Caylor, Truman E., Bluffton
Coble, Ralph R., Indianapolis
Cole, Ira, Lafayette
Conklin, Raymond L., Elkhart
Cook, G. M., Hammond
Crandall, L. A., Jr., Elkhart
Cummings, D. J., Brownstown

Daves, Lawrence W., Evansville
Derhammer, G. L., Brookston
Dunning, Lehman M., Indianapolis
Dyar, E. W., Indianapolis

Eaton, Marion J., Lafayette
Eikenberry, H. W., Indianapolis
Ellison, Alfred, South Bend
Eshleman, L. H., Marion

Faussett, C. Basil, Indianapolis
Fisk, Frank B., Indianapolis
Flatley, John A., Fort Benjamin Harrison
Frankowski, Clementine E., Whiting
Frost, John W., Indianapolis

Gaskill, Herbert S., Indianapolis
Gastineau, Frank M., Indianapolis
Gibson, Greta Maxine, Indianapolis
Graessle, H. P., Seymour
Grayston, Wallace S., Huntington
Grillo, Donald, South Bend

Hade, Frederick L., Bridgeport
Harris, Paul N., Indianapolis
Harstad, Casper, Rockville
Hattendorf, A. Paul, Fort Wayne
Hayes, Robert E., Fort Benjamin Harrison
Heilman, Wm. C., New Castle
Heinz, Dorothy C. V., Indianapolis
Henderson, Francis G., Indianapolis
Herzer, C. C., Evansville
Hines, Don Carlos, Indianapolis
Hoffmann, Sterling P., Fort Wayne
Holland, Philip T., Bloomington

Irey, P. R., Plymouth

Kahan, H. L., Gary
Klepinger, Harry E., Lafayette
Kohlstaedt, Kenneth G., Indianapolis

Littell, J. Jerome, Indianapolis

McCarty, Virgil, Princeton
McCaskey, C. H., Indianapolis

McIntyre, J. M., Indianapolis
Marks, Howard H., Huntington
Mendenhall, Edgar N., Fort Wayne
Mitchell, Albert M., Terre Haute
Moore, Will C., Muncie
Morrison, W. R., Kokomo
Murdock, Harvey L., Fort Wayne

Need, Louis T., Indianapolis
Nickel, Allen C., Bluffton
Nill, John H., Fort Wayne

Osterman, Louis H., Seymour
Ottinger, Ross C., Indianapolis

Patterson, William K., Anderson
Peck, Franklin B., Indianapolis
Perrin, K. F., Fort Wayne
Possolt, Thomas R., Elkhart
Price, M. D., Nappannee

Rabson, S. Milton, Fort Wayne
Ramsey, Frank B., Indianapolis
Records, Arthur W., Franklin
Reed, Roger R., Anderson
Reed, William C., Bloomington
Rhind, A. W., Hammond

Rice, Raymond M., Indianapolis
Rodin, Herman Harold, South Bend
Ross, Alexander T., Indianapolis
Ruddell, Karl R., Indianapolis

Sandoz, Louis A., South Bend
Schlaegel, T. F., Jr., Indianapolis
Schmoll, Robert J., Fort Wayne
Schuster, Dwight W., Indianapolis
Shattuck, John C., Brazil
Shoup, Homer B., Greentown
Smith, Herschel S., Bloomington
Smith, R. Lee, Osgood
Snively, W. D., Jr., Evansville
Stellner, Howard A., Fort Wayne
Stiver, D. D., South Bend
Stoelting, V. K., Indianapolis
Stork, Urban F., Evansville
Stout, Walter M., New Castle
Stoycoff, C. M., Gary
Stygall, James H., Indianapolis

Taylor, James A., Montpelier
Thompson, John M., South Bend

Van Bokkelen, Robert W., Mooresville
Viney, Charles L., Logansport

Webb, Harry D., Anderson
Weiss, H. G., Evansville
Wiedemann, Frank E., Terre Haute
Wilkins, Robert W., Fort Wayne
Wise, C. L., Camden
Worley, Ansel C., Fort Wayne.

SCIENTIFIC PROGRAM—ANNUAL CONVENTION INDIANA STATE MEDICAL ASSOCIATION

Twenty-one physicians, seven of them from out of the state, will participate in the scientific program during the 101st annual convention of the Indiana State Medical Association opening Monday, September 25, 1950, at French Lick.

The Committee on Scientific Work, in announcing the program, pointed out that efforts had been made to get top essayists to present papers on subjects which would have wide appeal. Two panel discussions, one on Tuesday, September 26, and the other the next day, will be composed exclusively of Indiana physicians.

The scientific program was released by the committee so that it could be printed in the August issue of THE JOURNAL, thus letting physicians know a month earlier than usual the time and subjects of the scientific papers. The complete program of the convention will appear in the September issue.

The scientific program follows:

Tuesday, September 26, 1950

10:10 a.m. **J. Neill Garber, M.D.,** Indianapolis
"Orthopedic Aspects of Arthritis"

10:30 a.m. **Edgar S. Gordon, M.D.,** Madison, Wisconsin
"Newer Developments in Arthritis Therapy"

2:00 p.m. Panel Discussion: *"Total Hysterectomy vs. Subtotal Hysterectomy in Benign Lesions of the Fundus"*
David A. Bickel, M.D., South Bend, Moderator,
Carl P. Huber, M.D., Indianapolis,
W. D. Inlow, M.D., Shelbyville,
James M. McFadden, M.D., LaFayette.

3:30 p.m. **David A. Boyd, Jr., M.D.,** Rochester, Minn.
"Psychological Language of the Organs"

3:50 p.m. **Mortimer Mann, M.D.,** Indianapolis
"Ocular Fundus Manifestations of General Disease"

4:10 p.m. **Hayes Martin, M.D.,** New York City
"The Diagnostic Significance of a 'Lump in the Neck'"

Wednesday, September 27, 1950

10:00 a.m. Panel Discussion: *"Uses and Abuses of Antibiotics and Antihistamines"*
Paul J. Fouts, M.D., Indianapolis, Moderator,
Kenneth L. Craft, M.D., Indianapolis,
Kenneth T. Knode, M.D., South Bend,
Hugh A. Kuhn, M.D., Hammond,
George W. Willison, M.D., Evansville,
Maurice S. Fox, M.D., Vincennes.

2:00 p.m. **R. M. S. Barrett, M.D.,** St. Louis
"Anesthesiology—Its Economics"

2:20 p.m. **Harris B. Shumacker, Jr., M.D.,** Indianapolis
"Vascular Surgery"

2:40 p.m. **Donald C. McClelland, M.D.,** LaFayette
"X-Ray Diagnosis for the General Practitioner"

3:30 p.m. **Francis E. Senear, M.D.,** Chicago
"Eczema of the Hand"

3:50 p.m. **Owen H. Wangensteen, M.D.,** Minneapolis-Rochester
"Intestinal Obstruction"

4:10 p.m. **S. Leon Israel, M.D.,** Philadelphia
"The Modern Treatment of Sterility"

"Doctors ARE Citizens"

These notes are presented at the request of many physicians who wish to participate as responsible citizens in the Congressional elections in their own localities—but who are concerned at the efforts of medicine's critics to deny them this privilege by designating such acts as "political meddling."

These are simple notes on what a doctor may or may not do, under the law, in connection with Federal elections.

This material was prepared from an interpretation of the Federal laws, by the law firm of Kirkland, Fleming, Green, Martin & Ellis, at the request of the American Medical Association, National Education Campaign Committee.

LEGAL ASPECTS OF DOCTORS' POLITICAL ACTIVITIES

1. **Legally, it is imperative that doctors who engage in active support of candidates do so as individual citizens—and not under the auspices of their Medical Societies.**
2. The American Medical Association cannot legally contribute to or expend funds in support of, or in opposition to, candidates for Federal office.
3. State and County Medical Societies, whether incorporated or not, are subject to the SAME limitation.
4. The law prohibits a Medical Society from:
   a. Endorsing a candidate, where it involves expenditure of general corporate funds
   b. Contributing funds to any candidate for Federal office
   c. Using Medical Society letterheads or facilities to advance work in behalf of a candidate
   d. Sponsoring any other form of advertising material for a candidate.
5. Individuals forming political committees must not make use of any official position or office which they may hold or occupy in any organization.
6. These limitations, which appear in the Hatch Act, the Corrupt Practices Act and the New Criminal Code, are sometimes violated by careless citizens.

   American doctors must conduct their activities wholly within the law.

THE POSITIVE SIDE

1. **It is the right and duty of every citizen aggressively to further the candidacy of any qualified candidate for Federal office and actively to oppose the candidacy of any candidate felt to be unqualified.**
2. Any group of citizens, whether on a National, State or County level, can as individuals form political action committees for this purpose.

POLITICAL ACTION COMMITTEES

1. Local political committees, operating within a **single** State, are not required to file detailed reports of expenditures and contributions.
2. A committee operating in two or more States, or as a branch or subsidiary of any National committee, must so file.

WHAT YOU CAN DO AS AN INDIVIDUAL

1. Contribute personally any sum up to a maximum of $5,000.00 to or on behalf of a candidate for Federal office.
2. Solicit and receive contributions for the same purpose, except from those persons who are prohibited from contributing—for example, from persons on relief, or persons holding contracts with the Federal Government.
3. Actively manage political campaigns or participate in them by writing, speaking or otherwise advocating a candidate's election.

HEALTH PLANKS OF 1950 INDIANA POLITICAL PARTY PLATFORMS

THE Republican and Democratic parties, at their state conventions held in Indianapolis in June, adopted platforms upon which they are campaigning for votes for the November 7 election. Knowing the interest of the medical profession in the parties' declarations on compulsory sickness insurance, we are printing below the "health planks" of their platforms:

REPUBLICAN

(1) HEALTH. The strength of the state depends upon the health of its citizens.

Great strides have been made in Indiana's public health program, which was inaugurated by the Republican Party in 1944-48. Continued support of this program is pledged.

In addition, it is recognized that the general welfare of the state of Indiana depends, to a very large extent, upon the public health status of the various communities of which it is comprised.

The state has a positive responsibility to all its citizens to help local government units solve their own health problems.

It is obvious that it is more economical and that more lives will be saved through the prevention of disease than in treating the results of disease.

(2) MENTAL HEALTH. We propose that Indiana's institutions and facilities for the care of the mentally ill shall be second to none in the nation.

The Republican Party originated the most progressive steps ever taken in the care of Indiana's mentally ill.

We hereby pledge ourselves to a continuation and improvement of the program begun by the Republican state administration in 1944-1948.

We advocate that all psychiatric techniques of proven value be made available to the patients.

We continue to support the establishment of mental health clinics, apart from the hospitals. Thus psychiatric services will be available to a far greater number of citizens.

We also propose that outpatient clinics be operated as a part of hospitals.

We advocate that all efforts shall be made to procure patients and not just give custodial care.

We demand that proper and special care be provided for deranged delinquents.

(3) SOCIALIZED HEALTH SERVICES. We will be constantly vigilant in the further improvement of a voluntary health program.

We will guard against the undermining influence of political control of the sick and unfortunate, the hospitals and the healing arts professions.

The Republican Party is vitally interested in good health and better medical facilities for all our people on a voluntary basis.

(Continued on page 800)

DEMOCRATIC

Remarkable progress by medical science in the discovery and development of new and more effective means of combating disease has been made during recent years. State-supported institutions, including Indiana University, have substantially contributed to this progress by educating and training thousands of medical experts who have made such advance possible. The state of Indiana has a large investment in the medical profession in Indiana.

Every person is entitled to the benefits of modern medical science; however, under existing conditions many people are being deprived of their inherent right to good health and freedom from disease because they are financially unable to pay the great cost of proper medical care in serious illness. The citizens of Indiana are justified in asking and expecting the medical profession, through its well-organized associations or otherwise, to take the initiative and assume leadership in developing ways and means to assure to all persons medical care to which they are entitled, irrespective of their financial ability to pay.

Both to the individual and to the community, good health is an asset and ill health is a liability. It is the inherent duty and responsibility of the state to protect the health and physical well-being of its citizens. In so far as such duty is not discharged through existing agencies and methods of the medical profession or otherwise, it devolves upon the state to see that such agencies are created and such methods are devised as may be necessary to assure and protect the right of every individual to adequate modern and scientific medical care.

In the event of continued failure of those agencies or methods, and in the absence of creation of any new effective means by them, the Democratic Party in Indiana pledges itself to support the development of those agencies and methods as may be necessary to assure every person such medical care.

Any health insurance plan should preserve the full professional freedom for doctors and be applicable only to those situations which the individual cannot, himself, normally meet; we oppose the regimentation of the medical profession or any effort to interfere with the confidential relationship between doctor and patient, believing that every person should be free to employ the doctor of his own

(Continued on page 800)

Just in Case You May Forget

1950 Annual Session

Indiana State Medical Association

FRENCH LICK

Monday, Tuesday and Wednesday
September 25, 26 and 27

Write Direct to the Hotel for Your Reservation!

HOTELS AND RATES

French Lick Springs Hotel, French Lick, Indiana
(American Plan)
Single room with bath.....$14.00 per day
Double room with bath.....$12.00 per day per person
Double room with lavatory and toilet .....$10.00 per day per person
Double room with running water .....$ 9.00 per day per person
Parlors .....$12.00 per day
For those persons staying outside the hotel the meal rate will be: Breakfast, $1.50; luncheon, $2.00, and dinner, $3.00, including tickets for the banquet Wednesday night, September 27.
Check-out hours are 11:00 a.m. and 4:00 p.m.

Grand Hotel, French Lick, Indiana
(European Plan)
Rooms with bath on halls—
Double $3.00, $2.50, $2.00
Single $2.00, $1.50, $1.00

Claxton House, French Lick, Indiana
(European Plan)
Rooms with bath on halls—
Double $2.00
Single $1.50

West Baden Springs Hotel, West Baden, Indiana*
(European Plan)
Double room with bath.....$5.00 double; $3.00 single
Double room with toilet (no bath) .....$4.00 double; $2.50 single
Double room with running water only .....$3.50 double; $2.00 single

Be sure to specify type of accommodations, and time of arrival and departure.

Schedule of Events

MONDAY, SEPTEMBER 25

Instructional courses, Council and House of Delegates meetings, golf and trap shoot, party for women at night, and the big stag jamboree.

TUESDAY, SEPTEMBER 26

Scientific papers, morning and afternoon. Dancing at night to music of name band.

WEDNESDAY, SEPTEMBER 27

Scientific papers morning and afternoon. Final meeting of Council and House of Delegates. Annual dinner, with nationally-known humorist as principal speaker.

* West Baden Springs is one mile from French Lick

ORDER YOUR TICKETS FOR THE 1950 INSTRUCTIONAL COURSE NOW!

The schedule of classes for the 1950 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at French Lick Springs Hotel, French Lick, is now complete. All classes are on Monday, September 25, 1950.

Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is $1.00 per class with a maximum charge of $3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now! Classes are filled early!

INSTRUCTIONAL COURSE SCHEDULE

Hrs.	Room A	Room B	Room C	Room D	Room E	Room F
11 to 12	Psychological Management of Patients Dr. K. I. Jeffries Course 1	Diagnosis and Treatment of Respiratory Diseases Dr. R. S. Henry Course 2	Pediatric Problems Dr. R. Hippensteel Course 3	Ear, Nose and Throat Problems Dr. Bert Ellis Course 4	The Backache Problem Dr. C. F. Thompson Course 5	Problems of Hypertension Dr. W. A. Shullenberger Course 6
NOON RECESS						
1 to 2	Bedside and Office Diagnosis of Cardiac and Vascular Problems Dr. A. T. Stone Course 7	Anemia and Blood Dyscrasias Dr. Philip Kurtz Course 8	Infant Feeding Problems Dr. S. A. Kauffman Course 9	Office Management of Anorectal Diseases Dr. J. W. Ricketts Course 10	Minor Home, Farm and Factory Emergencies Dr. A. K. Harcourt Course 11	Office Diagnosis and Treatment of Common Genitourinary Conditions Dr. John Hendricks Course 12
2 to 3	The Demonstration of a Diagnostic Neurological Examination Dr. E. Vernon Hahn Course 13	Bedside and Office Diagnosis of Cardiac and Vascular Problems Dr. E. P. Tischer Course 14	Problems in the Management of Rheumatic Fever Dr. M. Winters Course 15	The Diagnosis and Treatment of Common Skin Diseases Dr. Don E. Kelly Course 16	Corns, Bunions and Painful Feet Dr. G. W. Batman Course 17	Diagnosis and Management of Common Gynecological Conditions Dr. T. B. Noble, Jr. Course 18
3 to 4	The Demonstration of A Diagnostic Physical Examination Dr. J. O. Ritchey Course 19	The Management of Diabetes Mellitus Dr. O. E. Carter Course 20	Obstetrical Emergencies Dr. G. W. Gustafson Course 21	The Newer Drugs Dr. R. A. Solomon Course 22	Arthritis Dr. W. M. Dugan Course 23	The Management of the Menopause Syndrome Dr. Floyd S. Romberger, Jr. Course 24
4 to 5	The Headache Problem Dr. John H. Greist Course 25	The Examination and Management of Cancerphobia Dr. Ben B. Moore Course 26	Impotence and Infertility Dr. Ernest Rupel Dr. John Spahr Course 27	The Diagnosis and Treatment of Common Skin Diseases Dr. F. Gastineau Course 28	The Treatment of Colitis and Constipation Dr. A. G. Funkhouser Course 29	The Management of Problems of the Elderly Dr. Wm. E. King Course 30

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APPLICATION BLANK

Instructional Course Committee,
c/o Gordon W. Batman, M.D.,
723 Hume Mansur Building,
Indianapolis 4, Indiana.

Enclosed find check for $1.00; $2.00; $3.00. Please reserve tickets for the following Instructional Courses:

First choices	11:00 A.M. No.:	1:00 P.M. No.:	2:00 P.M. No.:	3:00 P.M. No.:	4:00 P.M. No.:
Second choices	11:00 A.M. No.:	1:00 P.M. No.:	2:00 P.M. No.:	3:00 P.M. No.:	4:00 P.M. No.:

(Insert course numbers plainly, please.)

I will pick up my tickets at the Registration Desk, September 25, 1950.

Signed: ..... M.D.

Address: .....

News Notes

The class of 1935 of Indiana University School of Medicine will hold a reunion at noon on Wednesday, September 27, in parlors A and B, at French Lick Springs Hotel.

The International College of Surgeons, United States Chapter, will hold its fifteenth Annual Assembly and Convocation in Cleveland, Ohio, October 31, November 1, 2, 3, 1950. George M. Curtis, M.D., Columbus, Ohio, is Chairman of the Assembly.

AMERICAN COLLEGE OF PHYSICIANS REGIONAL MEETING

On November 18, 1950, the American College of Physicians North Central Regional Meeting will be held in Madison, Wisconsin. Registration will begin at 8:00 A.M. and the meeting will consist of a series of scientific papers presented throughout the day. A scientific exhibit of wide general interest is planned in connection with the meeting.

This gathering will be held in the Wisconsin Union Theater on the campus of the University of Wisconsin.

This postgraduate instructional session is open to all physicians, whether or not they are members of the American College of Physicians. Members of the College are urged to bring along their colleagues as guests.

AMERICAN COLLEGE OF SURGEONS MEETS IN BOSTON IN OCTOBER

Color television of surgical procedures from Massachuetts General Hospital to an auditorium in Mechanics Hall is one of the features planned for the thirty-sixth Clinical Congress of the American College of Surgeons which will be held in Boston from October 23 to 27, according to an announcement by Dr. Paul R. Hawley, Director. Twenty-four hospitals in Boston and vicinity will hold operative clinics for the visiting surgeons during the week. Official meetings, scientific sessions, medical motion pictures, a large technical exhibit, and the twenty-ninth annual Hospital Standardization Conference are among the other features of the extensive program, which is expected to attract around five thousand surgeons and hospital representatives from the United States, Canada, and other countries. Hotel headquarters will be at The Statler and Copley Plaza.

The class of 1907 of Indiana University School of Medicine will hold a reunion luncheon on Wednesday, September 27, at French Lick Springs Hotel, during the state convention. Luncheon room announcement will be made on the bulletin board in the lobby of the hotel.

The 85th annual session of the Michigan State Medical Society will be held September 20, 21 and 22, at the Book-Cadillac Hotel in Detroit. Physicians from neighboring states have been invited to attend.

Harris B. Schumacker, Jr., M.D., of Indianapolis, is one of the speakers on the program.

The annual convention of the **National Society for Crippled Children and Adults** will be held October 26, 27 and 28, 1950, at the Stevens Hotel, Chicago. Marking 29 years of service for the Society, the convention will feature prominent authorities working in the field of the disabled, who will present latest developments in the treatment, training and care for the nation's handicapped children and adults.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The annual meeting of the Board was held in Atlantic City, New Jersey, from May 21 to 27 inclusive, 1950, at which time 259 candidates were certified.

New Bulletins, incorporating changes made at the recent meeting, are now ready for distribution. These changes include adoption of a special form to be designated as the "Appraisal of Incomplete Training Form" which will be forwarded to prospective applicants upon request. Numerous changes concerning graduate training in obstetrics and/or gynecology have also been adopted and will be of special interest to hospitals conducting residency programs as well as to prospective applicants to this Board.

The next scheduled examination (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States and Canada on Friday, February 2, 1951. Application may be made until November 5, 1950. Application forms and Bulletins are sent upon request made to Paul Titus, M.D., Secretary, American Board of Obstetrics & Gynecology, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

CANCER GRANTS

Public Health Service grants to intensify the nation-wide attack on cancer were announced recently. Included were two for Indiana: $6,480 to Dr. John H. Van Dyke, at Indiana University in Bloomington, for research in extrinsic factors influencing abnormal development (an experimental analysis of ultimobranchial tissue neoplasms in the mammalian thyroid gland); and $7,200 to Dr. Kenneth N. Campbell, at the University of Notre Dame, for research in synthesis of possible chemotherapeutic agents for cancer. The grants were made by the National Cancer Institute, following recommendation by the National Advisory Cancer Council, and approval by Dr. Leonard A. Scheele, Surgeon General of the Public Health Service.

Indiana University Medical Center has been awarded $126,350 for new cancer research laboratories by the Federal Security Administration.

FELLOWSHIP PROGRAM IN INDUSTRIAL MEDICINE ESTABLISHED BY THE ATOMIC ENERGY COMMISSION

A fellowship program for training a limited number of industrial physicians will be started by the Atomic Energy Commission this fall, if qualified candidates can be obtained.

During the 1950-51 academic year up to four qualified candidates will be selected for academic training in industrial medicine. The stipend for Fellows will be $3,600.

Two of the Fellows selected this year will be sent to the School of Medicine, University of Rochester, Rochester, New York, and two will enter the Department of Occupational Medicine, School of Public Health, University of Pittsburgh. Prospective applicants should have completed a medical course and a satisfactory internship, plus one year of residency in internal medicine or its equivalent.

Application forms for AEC Industrial Medicine Fellowships may be obtained from the AEC Industrial Medicine Fellowship Committee, Division of Biology and Medicine, Atomic Energy Commission, Washington 25, D. C.

James Sidell, a junior from Monroeville High School, Monroeville, Indiana, won second prize ($500) in the nation-wide Essay Contest, "Why the Private Practice of Medicine Furnishes this Country With the Finest Medical Care," which was sponsored by the Association of American Physicians and Surgeons. He became eligible for the national competition when his essay won second prize in the contest sponsored by the Allen County Medical Society of Fort Wayne.

EXAMINATION FOR REGULAR CORPS MEDICAL OFFICERS

A competitive examination for appointment of Medical Officers in the Regular Corps of the United States Public Health Service will be held on October 9, 10 and 11. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received not later than September 11.

Application forms and additional information may be obtained by writing to the Surgeon General, United States Public Health Service, Federal Security Agency, Washington 25, D.C. Attention: Division of Commissioned Officers.

Medical Officer positions in the Federal Service paying $5400, $6400, and $7600 per year will be filled from an examination recently announced by the Director, Eighth U. S. Civil Service Region, Saint Paul, Minnesota. Positions paying the above cited salaries are now vacant and there is an immediate need to fill these positions. Medical doctors who have just completed their internship are eligible for the positions paying $5400. Medical doctors with one or two years experience performing responsible medical doctor duties are eligible for the positions paying $6400 and $7600 per year respectively.

Applications for these positions will be accepted until further notice. Application forms may be obtained at any first- or second-class post office. A copy of the examination announcement may be obtained by writing the Director, Eighth U. S. Civil Service Region, Saint Paul Post Office and Customhouse Building, Saint Paul 1, Minnesota.

To keep military Reserve Medical Officers of the Armed Forces, Army, Navy and Air Force posted on the latest developments in the field of Medical science, a Medico-Military Symposium for officers of the Fourth Naval District will be held at the U. S. Naval Hospital, Philadelphia, Pennsylvania from October 23 to 28. Speeches and panel discussions are scheduled in aviation medicine, national defense in case of disaster or attack, national preparedness, psychiatry, submarine medicine, surgery and orthopedics.

It is urged that officers make hotel reservations well in advance, since no government housing facilities will be available. The final session of the symposium will be held Saturday morning, October 28, leaving the afternoon free for officers to attend the Penn-Navy football game.

The attendance to this symposium is not restricted to Medical Officers of the Armed Forces. All members of the medical profession are cordially invited to attend.

Residents of Walton paid homage to **Dr. E. P. Flanagan** on July 30, which was set aside as "Doc Flanagan Day" there. Doctor Flanagan has practiced in Walton since 1918.

Dr. Kenneth L. Craft, of Indianapolis, assisted in the presentation of the third annual course in Nasal Allergy at the Hansel Foundation of Nasal Allergy, in St. Louis in June.

Dr. Lyman R. Pearson, of Indianapolis, read a paper on "Prevention and Treatment of Post-operative Complications of Anorectal Surgery," before the American Proctologic Society, on July 4, at Los Angeles.

Dr. Noel Graves, of Muncie, has become associated with **Dr. Harold Griffith**, at Vevay, in the practice of medicine. Doctor Graves is a graduate of Indiana University School of Medicine, and recently completed his internship at Methodist Hospital, in Indianapolis.

Dr. Jack Leo Hargan, of Fort Wayne, will practice medicine there. He is a graduate of Indiana University School of Medicine, and recently completed his internship at the Methodist Hospital, in Indianapolis.

Dr. H. R. Hoeger, who has been practicing medicine in Brookville, has gone to New Orleans, for a special course in otolarynology at Tulane University.

Dr. Richard Ko, who recently completed his internship at Ball Memorial Hospital in Muncie, has opened an office for the practice of medicine in Eaton. He is a graduate of Tulane University School of Medicine.

A recent graduate of Indiana University School of Medicine, **Dr. Elmer Koch** has opened an office in Danville.

Dr. Ray D. Miller, of Indianapolis, has been appointed medical director of the Martinsville Mineral Springs Sanitarium. He was formerly associated with the Home Lawn Sanitarium, following his graduation from Indiana University School of Medicine, and before his service with the armed forces, from 1941 to 1945. Following his release from service, Doctor Miller entered the private practice of medicine in Indianapolis, where he was on the staff at the Indiana University Medical Center.

A 1943 graduate of the Louisville Medical School, **Dr. Arthur M. Schoen** has returned to New Albany to establish a practice. He has recently been in practice in Philadelphia.

Dr. Robert Turgi has opened an office for the practice of ophthalmology and otolaryngology in Gary. A graduate of Indiana University School of Medicine, he interned at Cook County Hospital, in Chicago, before entering the service. Following his release from service, Doctor Turgi took post-graduate work at Wesley Memorial Hospital and Hines Veterans Hospital, in Chicago.

Dr. T. R. Crawford, who has been associated with the Associated Physicians and Surgeons Clinic in Terre Haute for the past year, has moved to Kokomo to practice.

Dr. Bronie Vingus has opened an office in Greenfield for the practice of medicine. A 1949 graduate of Indiana University School of Medicine, he recently completed his internship at the Methodist Hospital in Indianapolis. He is a veteran of World War II, with three years service overseas with the 94th infantry.

Dr. George M. Buehler has opened an office for the practice of medicine in Jeffersonville. He is a graduate of the University of Louisville School of Medicine, in 1946, and interned at St. Joseph's Hospital in Louisville, where he also spent a year as resident in internal medicine. Doctor Buehler spent one year with the Kentucky State Hospital, in Danville, as neuropsychiatrist, and spent one year in general practice at Willsburg, Kentucky.

Dr. William B. Clark, Jr., has returned to Jeffersonville to establish a practice in general medicine. He is a graduate of the University of Louisville School of Medicine, and interned at Clark County Memorial Hospital at Winchester, Kentucky, and Good Samaritan Hospital, Lexington, Kentucky. He is a veteran of World War II, where he served as a bomber pilot in the AAF.

Dr. H. J. Henry, of Knox, has moved to South Bend, where Doctor Henry will take special work at the Memorial Hospital. **Dr. Clark McClure** has taken over Doctor Henry's practice at Knox. Doctor McClure is a graduate of Indiana University School of Medicine. He is a veteran of World War II, where he served in the European Theater.

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Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1949, Xanthine Derivatives, Philadelphia, J. B. Lippincott Company, 1949, p. 323.

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Dr. James H. Stygall, of Indianapolis, was elected chairman of the Board of Regents of the American College of Chest Physicians, when that organization met in San Francisco in June.

Dr. Richard R. Hughes, a 1943 graduate of Indiana University School of Medicine, opened an office for the practice of surgery in Lafayette in July. He is a veteran of World War II, and recently completed his residency at the Indianapolis Medical Center.

After completing a residency in radiology at the Cold Springs Veterans Hospital, in Indianapolis, Dr. William E. Gallo has accepted a position with the VA hospital in Butler, Pennsylvania. A 1939 graduate of Georgetown University Medical School, Doctor Gallo spent eighteen months in the service.

Dr. E. Bryan Quarles has been appointed director of the Student Health Service of Indiana University, it was announced recently by President Herman B Wells.

The appointment of the new director fills a vacancy which has existed since 1947. Dr. Edith B. Schuman will continue as executive secretary of the Student Health Service.

A native of Richmond, Virginia, Doctor Quarles is a graduate of the University of Richmond and of the Medical College of Virginia. Prior to the last war he engaged in private practice in Alabama and was assistant superintendent of Barnes Hospital, St. Louis. During the war he held administrative assignments with the army air force and in 1946 returned to Barnes Hospital as associate director. Since 1948 he has been with the Veterans Administration as director of hospitalization and requirements service in its department of medicine and surgery.

A.M.A. WASHINGTON OFFICE NEWS

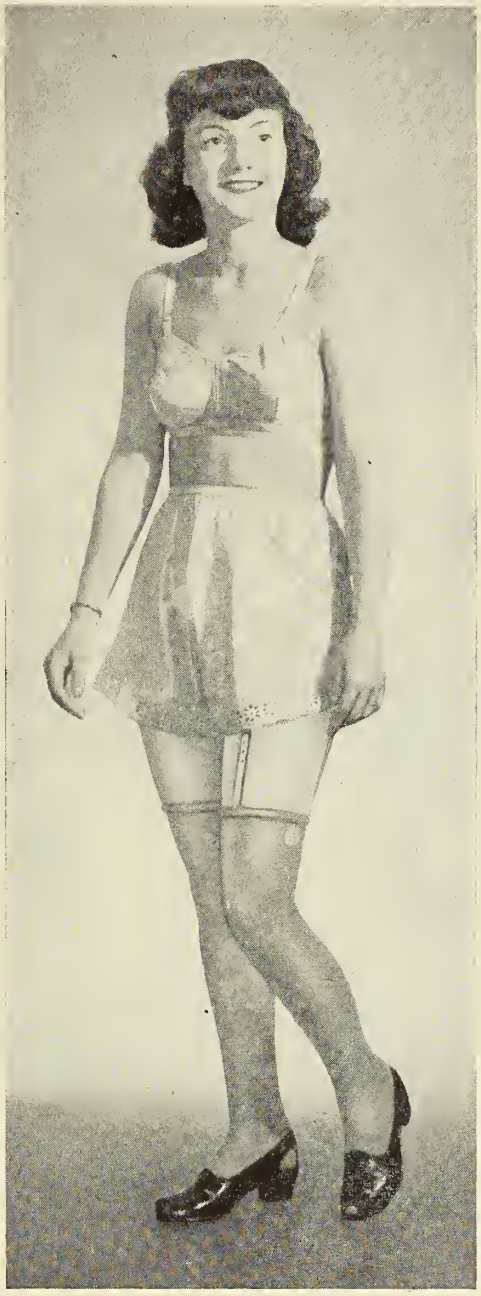
UMW Medical Program Resumes. *United Mine Workers* medical service program, *largest such industrial plan in the country*, has resumed operations, but with important restrictions. Under the old plan disability pensioners received free drugs as well as free home and office calls. Now all members are treated alike, but drugs and calls are no longer free. The new regulations authorize free obstetrical service only when the patient is certified as a hospital case. Also, psychiatric treatment will not be given, but diagnosis of such illness will be continued.

FTC Cites Another Anti-Histamine Producer; Army Issues Report On Drugs. Grove Laboratories, Inc., of St. Louis, is the *fifth* seller of anti-histamine preparations to be named in a complaint by the Federal Trade Commission. FTC claims the company has misrepresented therapeutic properties and effectiveness of its product, Antamine, in treatment of the *common cold*. It also questions the safety of the product. FTC says that Antamine advertising is misleading, unfair and deceptive. . . . Meanwhile, the Armed Forces Epidemiology Board, in an official report, maintains that the anti-histamines are *useless* against true cases of *common colds*. Subjects suffering from *allergies* were eliminated from the group tested, so the report does not go into the effectiveness of anti-histamines on *allergic persons* who might believe they were suffering from colds.

Civil Defense 'Pilot Operation' Well Under Way. Washington, D.C.'s week-long effort has produced the first rough-draft plan of what a large city should do in case of an atom-bomb attack. The outline is now in the hands of the National Security Resources Board, which will make its suggestions and refer the plan back to the various committees, including public utilities, medical groups, fire, police and water department. When amended, the outline will be sent to Seattle, then Chicago, which will use it as a guide in similar city-wide studies. A final standard pattern should be ready by *September 1*.

Dr. Dean A. Clark to Head Voluntary Health Insurance Survey. *Dr. Dean A. Clark* will head the Senate Labor and Public Welfare subcommittee survey of voluntary health insurance plans. Doctor Clark, General Director of Massachusetts General Hospital, was in charge of the New York State Health Insurance Plan for four years. Appointment of a Democrat and a Republican to assist Doctor Clark in the study of the country's national, state and local voluntary plans and their coverage is expected within a week. Under the Senate resolution (S. Res. 273) the committee must report its findings and recommendations to the Senate by February 1, 1951.

THE BARDACH-SCHOENE VACULIMB*



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Progress Report on Health Plan Politics. We now have an indication of some organizations ordering large lots of *"Better Medical Care that You Can Afford,"* the Truman plan propaganda pamphlet. Purchasers of wholesale quantities include Greater Detroit and Wayne County Industrial Union Council, Mich.; Tennessee State Industrial Union Council, Nashville; Brotherhood of Railroad Trainmen and Amalgamated Lithographers of America (CIO), and CIO's Political Action Committee.

Washington Setting Up Civil Defense "Pilot Operation." Physicians of *Washington, D. C.,* are out in the lead in preparing their part of a municipal emergency defense plan. The Washington Post comments: ". . . the *doctors* have shown themselves anxious to cooperate and are far more ready than the District Commissioners." Plans now being worked out by private and public organizations will be submitted to the National Security Resources Board. Later the blueprints, with any NSRB amendments or recommendations, will be sent on to *Seattle.* Seattle, in turn, will review the plans, possibly try them out in modified form, then send them to *Chicago.* Chicago will repeat the process. NSRB hopes that out of the three-city effort will come a program suitable for adaptation to other cities.

Drugs: Federal Trade Commission action against five antihistamine manufacturers has ended in an agreement. The manufacturers agreed in writing to *cease* advertising that the drug will *cure, prevent* or *shorten* the *common cold.* However, the companies are not required to cease making claims that the drug will relieve or sometimes stop such symptoms as sneezing, watering eyes, simple throat coughs and nasal congestion, but they may continue these claims only if they are supported by research. Also, the companies will be allowed to state that their products are *"safe if taken in accordance with directions on the lobel."* The FTC had objected to such claims, even though Food and Drug Administration raised no objection. . . . For the first time, cortisone now is available for widespread distribution to hospitals. Merck & Co. has the approval of FDA to allocate part of its increasing production to the 6,500 hospitals registered by AMA. Each will be allotted 900 milligrams of the drug. Increased production also has allowed the company to lower its price from $200 per gram a year ago to about $95.

The schedule for the Instructional Course Program will be found on page 791

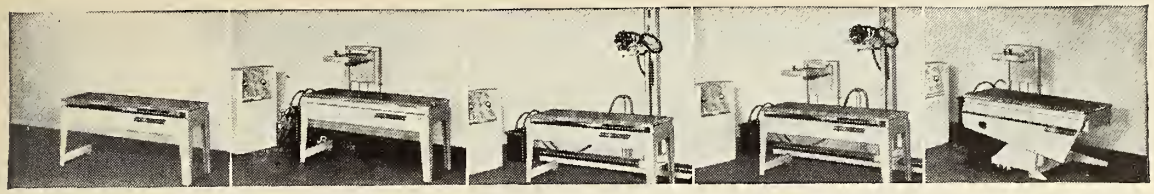
Senator Lehman Is Not Opposing Truman Plan. Contrary to newspaper stories, *Senator Herbert Lehman* (D.-N. Y.) has *not* come out in opposition to the Thomas-Murray-Dingell Bill, S. 1679. Misunderstanding arose over a speech the Senator made before the Greater New York Hospital Association, which was later printed in the Congressional Record. *Newspapers* said Senator Lehman had opposed the "Truman Plan." A careful reading of the text shows that *Senator Lehman made no mention of the bill,* and that he said *nothing that properly could be considered as opposition.* This is confirmed by the Senator's office, where we were told that he did not intend to give the impression he was opposing the Truman Plan. The fine point here is that its sponsors insist the Truman Plan for national compulsory health insurance is *not socialistic* and that it would *not regiment* the profession or hospitals.

Hanford Plant Physicians Switch To Private Practice. Effective May 1, physicians and dentists at the Hanford, Wash., plant of Atomic Energy Commission switch over from contract medicine to *private practice* of medicine. About 20,000 workers and their dependents are involved. AEC officials in Washington, discussing the change, said it resulted from an agreement between the plant's medical service department and the physicians and dentists. Before the decision was made, a group of hospital consultants and a second group of nationally known specialists studied the situation and *recommended* that the *salary-plus-bonus plan* be dropped in favor of *private practice.*

This leaves only one AEC project town—Los Alamos — operating under contract arrangement for medical care. Physicians at Los Alamos probably will continue to be employed through the hospital because the population is considered too small to insure adequate hospital facilities or to support the necessary number of specialists under private practice. Oak Ridge, the third AEC town, received its early medical care from Army doctors. Later, physicians were employed through the hospital. About a year ago Oak Ridge made the break to unrestricted private practice.

Commenting on the change to private practice at Hanford, General Manager G. R. Proud said: "We are happy to be able to take this additional step *to encourage the American system of private enterprise.*" Fred L. Schlemmer, AEC'S top man at Hanford, said management was *"completely satisfied"* that the change could be made.

In another move away from group or socialized medicine, an advisory board of trustees has been appointed for the Hanford hospital. Although the hospital still is government-owned, the trustees will function in much the same manner as trustees of private hospitals.



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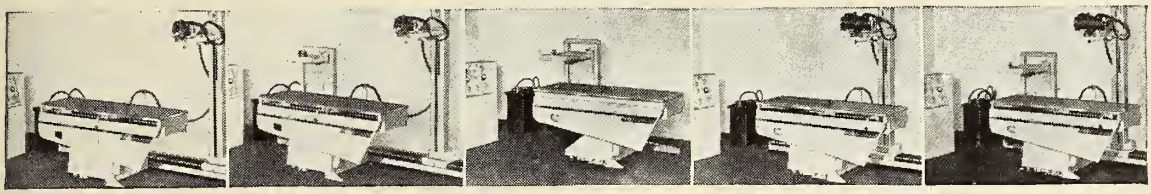

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The Maxicon series has a wealth of utility wherever diagnostic x-ray is employed. The practicing physician may select the basic unit, then let x-ray grow with his practice — by simply adding successive components from time to time. The medical specialist may arrange to have only the x-ray facilities his specialty requires.

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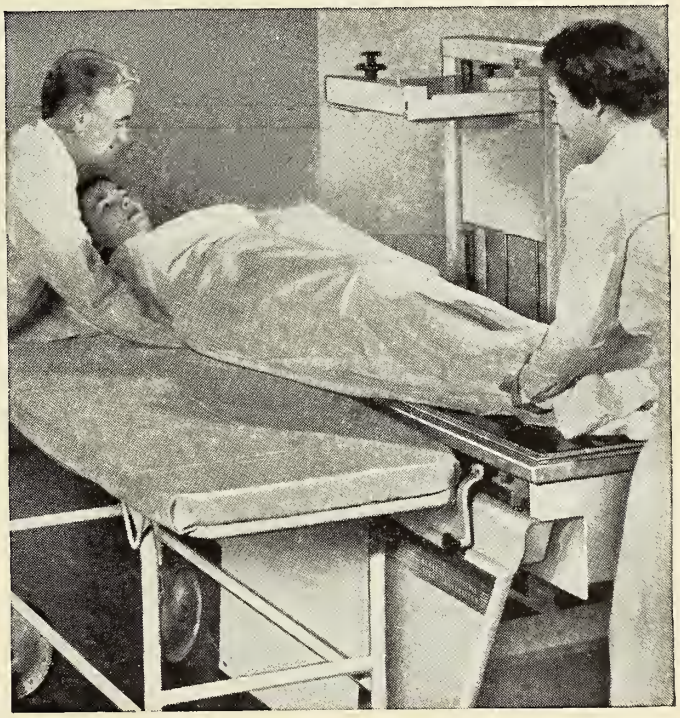

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Deaths

James William Wiltshire, M.D., died at his home in Bloomington on June 20, at the age of 78 years, following fifty-two years of medical practice. In 1948 he had been awarded a fifty-year service pin by the Owen-Monroe Counties Medical Society. He was graduated in 1896 from the Chicago Homeopathic Medical College, and located in Bloomington the following year. Besides his honorary membership in the local medical society and the Indiana State Medical Association, he was a member of the American Medical Association.

Leslie Howe Maxwell, M.D., formerly of Indianapolis, died on June 28 at Fort Lauderdale, Florida where he made his home since 1923. He was 65 years of age. After graduating in 1909 from the Indiana University School of Medicine, Bloomington and Indianapolis, he interned at Methodist Hospital, Indianapolis, and served as a captain in the Medical Corps during World War I.

Elizabeth Conger, M.D., age 78, died on Wednesday July 5, at Indianapolis. Born in Pittsboro she graduated from the Medical College of Indiana, Indianapolis, in 1897, and practiced medicine in Indianapolis with her husband, the late Charles Conger, M.D. She was an honorary member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Charles Frank Hardy, M.D., of Kendallville, died on June 26 in Fort Wayne, at the age of 79 years. He was a graduate of the Hahnemann Medical College and Hospital in Chicago, in 1895, and had practiced medicine in Kendallville for 55 years. He was a member of the Noble County Medical Society, the Indiana State Medical Association, and the American Medical Association.

HEALTH PLANKS OF 1950 INDIANA POLITICAL PARTY PLATFORMS

(Continued from page 789)

REPUBLICAN

We therefore pledge our vigorous opposition to any socialistic compulsory health plan under the direction of the government, whether it be called the Truman-Ewing compulsory health program, "socialized medicine," "health insurance," "state medicine," or masquerades under any other name.

The passage of a compulsory health plan would be detrimental to patients as individuals. It would be a wasteful expenditure and would result in more burdensome taxes for everyone.

It would greatly impair the efficiency of those engaged in caring for the sick and afflicted, and all public health would be endangered by the lower quality of treatment and service available.

DEMOCRATIC

choosing and that the doctor in the conscientious discharge of his professional duties should not be hampered by incumbering regulations or restrictive supervision.

We propose and advocate the following:

1. Retention of existing laws providing for the present high standards, requirements and functions of the healing art.

2. Federal and state aid in financing the establishment and construction of public hospital facilities in those localities not otherwise supplied, and guaranteeing them full freedom of hospital management on the local level.

3. Aid by the state in the establishment and maintenance of local health departments for the purpose of carrying out the responsibility of the state for providing trained service and scientific leadership in public health to all communities.

4. Continuance of an aggressive stream pollution control program.

5. Continuance of efforts toward improvements in the treatment of the mentally ill.

6. Extension of the program to improve the health of the children of the state.

We commend the State Board of Health for the manner in which it is carrying out the state's responsibility for providing service and leadership in public health.

The Democratic State Administration under the leadership of Governor Henry F. Schricker merits the respect and commendation of all citizens of Indiana for the improvements achieved in the conditions of Indiana's mental hospitals since January, 1949, with emphasis on cure and not mere custodial care.

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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

A PRIMER FOR DIABETIC PATIENTS. By Russell M. Wilder, M.D., professor and chief of the Department of Medicine of the Mayo Foundation, University of Minnesota, senior consultant in the Division of Medicine, Mayo Clinic. 9th edition. 200 pages with 8 figures. Price $2.25. W. B. Saunders Company, Philadelphia, 1950.

TEXTBOOK OF ENDOCRINOLOGY. Edited by Robert H. Williams, M.D., executive officer and professor of medicine, University of Washington Medical School, Seattle. 793 pages with 168 figures. Price $10.00. W. B. Saunders Company, Philadelphia, 1950.

PARKINSON'S DISEASE. By Walter Buchler, London, England. 79 pages. Price $2.00. Walter Buchler, 101 Leeside Crescent, London, N.W. 11, England, 1950.

BREAST DEFORMITIES AND THEIR REPAIR. By Jacques W. Maliniac, M.D., clinical professor of Plastic Reparative Surgery and associate attending Plastic Reparative Surgeon, New York Polyclinic Medical School and Hospital, New York City. 193 pages with 119 illustrations. Price $10.00. Grune & Stratton, Inc., 381 Fourth Ave., New York City, 1950.

PSYCHIATRIC SECTIONS IN GENERAL HOSPITALS. By Paul Haun, M.D., assistant professor of Psychiatry, Georgetown University Medical School, Washington, D.C. 80 pages. Price $4.00. Architectural Record, F. W. Dodge Corp., 119 West 40th Street, New York 18, New York, 1950.

AMUSING QUOTATIONS FOR DOCTORS AND PATIENTS. Edited by Noah D. Fabricant, M.D. 149 pages. Price $3.00. Grune & Stratton, Inc., 381 Fourth Avenue, New York 16, N. Y., 1950.

SEX WITHOUT FEAR. By S. A. Lewin, M.D., and John Gilmore, Ph.D. 121 pages, with 46 illustrations. Price $3.00. Lear Publishers, Inc., 105 East 15th Street, New York 3, New York, 1950.

THE MERCK MANUAL OF DIAGNOSIS AND THERAPY. 8th Edition. 1,592 pages. Price $5.00. Published by Merck & Co., Inc., Rahway, New Jersey, 1950.

HISTOLOGY. By Arthur Worth Ham, M.B., professor of Anatomy, in charge of Histology, in the Faculties of Medicine and Dentistry, University of Toronto, Canada. 766 pages, with 445 figures, including 4 color plates. Price $10.00. J. B. Lippincott Company, East Washington Square, Philadelphia, Pa., 1950.

WORLD SURGERY 1950. By Stephen A. Zieman, M.D., abstract and news editor, *Journal of the International College of Surgeons.* 177 pages, with 53 illustrations. Price $6.00. J. B. Lippincott Company, East Washington Square, Philadelphia, Pa., 1950.

THE MASK OF SANITY. By Hervey Cleckley, M.D., professor of psychiatry and neurology, University of Georgia School of Medicine, Augusta, Georgia. Second Edition. 569 pages. Price $6.50. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis, Missouri, 1950.

ESSENTIALS OF OPHTHALMOLOGY. By Roland I. Pritikin, M.D., eye surgeon, Rockford Memorial, Winnebago County, and Swedish-American Hospitals, consulting ophthalmologist, St. Anthony Hospital, Rockford, Illinois. 561 pages, with 215 illustrations, including 18 in color. Price $7.50. J. B. Lippincott Company, East Washington Square, Philadelphia, Pa., 1950.

THE PRACTICE OF MEDICINE. By Jonathan Campbell Meakins, M.D., formerly professor of medicine and director of the Department of Medicine, McGill University. Fifth edition. 1,558 pages, with 518 illustrations, including 50 in color. Price $13.50. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis, Mo., 1950.

SEXUAL DEVIATIONS. By Louis S. London, M.D., diplomate American Board of Psychiatry and Neurology; Frank S. Caprio, M.D., member American Psychiatric Association; with a foreword by Nolan D. C. Lewis, M.D., professor of psychiatry, College of Physicians and Surgeons, Columbia University, director New York State Psychiatric Institute and Hospital, editor. The Psychoanalytic Review. 702 pages. Price, $10. The Linacre Press, Inc., Washington, D. C., 1950.

Owing to the fact that about 90 percent of this book consists of illustrative case histories, it is impossible in a short review to go into much detail. The chief importance of the work is the author's thesis that "sexual deviations are not pathological entities but merely represent symptoms of underlying neuroses of an obsessional type; that sexual inversion as a symptomatic disorder in both sexes is curable; that sexually aberrated individuals can be treated most successfully via the method of psycho-analytic psychotherapy." They insist that homosexuality is not congenital, as many have supposed, and cite much evidence in the case histories to show it is acquired, and the mechanism of its acquisition.

For the physician who has had no specialized training in psychiatry the third section of the book is the important part, as it contains in 40 pages the general discussion of therapeutic and sociological aspects of the problem, including psychosomatic ailments associated with sexual pathology, medico-legal management of sex offenses, et cetera. This book is an interesting corollary, or should we say parallel—to the one by Kinsey, Waddell and Martin.

A. W. C.

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BOOKS REVIEWED

QUESTIONS Medical State Board and ANSWERS. By R. Max Goepp, M.D., formerly professor of clinical medicine, Graduate School of the University of Pennsylvania, and professor of medicine, Woman's Medical College of Pennsylvania; and Harrison E. Flippin, M.D., associate professor of medicine at the Graduate School of the University of Pennsylvania. 8th edition. 663 pages. Price $7.00. W. B. Saunders Company, Philadelphia, 1950.

This is the eighth edition of a book which has been used by medical graduates, preparing for state board examinations, for over forty years. Such a record amply recommends the work to all physicians who are preparing for state board examinations. Although written primarily for this purpose, the book can serve as a general outline for review, and may be profitably used by any physician, especially one who may have been out of practice for a time.

In this edition only the section on anatomy, which was revised in the seventh edition, has not been changed. Because of great advances in medicine, especially in therapeutics, extensive revision has been necessary. This apparently has been done in collaboration with competent medical authorities.

The book can be recommended to all physicians who are preparing for state board examinations.

D.A.B.

SOCIETY AND ITS CRIMINALS. By Paul Reiwald, reader in criminology in the University of Geneva; translated and edited by T. E. James, barrister-at-law. 315 pages. $4.50. International Universities Press, Inc., New York City, 1950.

This volume, written by an authority in the field of criminology, adds much to the development of positive attitudes towards the treatment of the criminal. Mr. Reiwald states that criminal law and criminality presuppose one another. In the beginning of the nineteenth century, when terrible punishments were carried out in England, every twenty-second man was a criminal. The author states that a change for the better occurred when a more reasonable criminal law was established.

The author in his book stresses the need for a psychology of the society which inflicts punishment. This is needed to lessen and modify the emotion which society experiences in punishment, this being necessary to clear the path for a reasonable treatment of the criminal, who the author feels should be categorized as an asocial person. The author stresses the use of the psychoanalytic technique to bring about a better understanding of the criminal. He states that this method seeks to bring unconscious emotions and conflicts which find expression in punishment into consciousness and so make them capable of control. The author states that in order to make further advances in this field the attitude of society which inflicts the punishment must be changed to attain any real alteration in criminality. He feels that the resistance of the lawyer to such advances in practice has been due to the formal education of the lawyer, the lack of correlation between theory and practice, the state of legal history, which is bogged in factual preoccupation, and the attitude of the judge towards the criminal whom he does not know, does not wish to know, cannot get to know, and yet upon whom he must sit in judgment.

In later chapters the author points out the identification between the judge and the father, stating that the father often represents the judge in childhood and therefore in later life the judge represents the father figure in man's conscious. The psychoanalytic dynamics, which the author uses to stress this identification, are pointed out in detail. The author also adds that the jury, in reality, came into being as a revolt against the father and the judge.

A discussion of the criminal in fantasy, as well as the psychology of the crime novel, is also carried out in great detail. In his discussion of the criminal in reality, the author states that in reality there is a small number of criminals. As a substantiation of this belief, he quotes Anderson of England and Hiendl of Germany. Hiendl, as quoted, states, "The number of professional crimes committed is enormous but the number of rogues who commit these crimes is surprisingly small."

The author also discusses the genesis of punishment as well as the part of aggression in criminal law. The concluding chapter of the book is an especially good one. The author states that the future criminal law depends upon replacement of aggression in criminal law. He cites the experiments of August Aichhorn, who made social beings out of the aggressive inmates of his institution for wayward children by the use of absolute kindness and mildness, continual occupation and plenty of play as a preventive for the aggressive instincts as well as constant discussion with every individual. The author also cites the accomplishments brought about at the work colony of Bolschewo, where hundreds to thousands of inmates were helped a great deal by the principle of self-government. The author further adds that a number of leaders who have dedicated themselves to the rehabilitation of the asocial person have found their efforts unsuccessful because of their inability to transform the attitudes of society.

The author feels that aggression in criminal law should be replaced by nonviolence and self-government as a means of education. He further points out that the main body of asocial individuals in America is made up of the 19-year-olds and the problem is paramountly a question, therefore, of the asocial young person. He feels that society must improve the entire criminal law relating to young persons by applying the principles of nonviolence and self-control.

The adult asocial person should also be isolated from force and aggression and helped to make good the damage that has already been sustained. In carrying out this program, compulsory work would play an important role. In formulating this plan, the author eliminates two types of criminals who must be excluded from this plan—the murderer and the serious sex offender. For the first, he feels that the question of possible painless death must be considered; the second must be treated with life-long preventive detention, compulsory work also being a part of the program. One of the concluding remarks in the book is a quotation from Forel, the great Swiss scholar, which is as follows: "In my opinion, the seat of criminal law lies in its abrogation, that is, in the removal of all right to punish."

The book is well written and should be of interest to all individuals who are concerned with the criminal and his treatment.

M. F. G.

BOOKS REVIEWED

DISEASES OF THE HEART. By Charles K. Friedberg, M.D., associate physician Mt. Sinai Hospital, New York. 1081 pages with 79 figures. Price $11.50. W. B. Saunders Company, Philadelphia, 1949.

The outstanding characteristics of this book are its excellent organization and comprehensive scope. All aspects of heart disease are thoroughly and painstakingly discussed. The author is careful to present conflicting theories regarding the pathogenesis and etiology of heart lesions in an unbiased manner; he has emphasized the pathogenesis of heart disease in accordance with the present trend toward the study of physiology and its alterations during disease. The bibliography is voluminous and contains many referrals to the foreign literature. The author has deliberately omitted a discussion of electrocardiography.

This book should be of most value as a reference book. It is highly recommended for practitioners and students.

H.M.T.

HANDBOOK OF OBSTETRICS AND DIAGNOSTIC GYNECOLOGY. By Leo Doyle, M.D., Berkeley, California. 240 pages, with 45 figures. Price $2.00. University Medical Publishers, Palo Alto, California, 1950.

This small volume contains a surprising amount of factual material pertaining to obstetrics and gynecologic diagnosis. The book is well prepared; there is a complete table of contents and a comprehensive index. The material is presented in outline form and is embellished by lucid pen drawings, which render ideas readily comprehensible, even to the beginner. The ideas presented are on the whole sound and modern. There are many useful tables for quick reference pertaining to normal laboratory values.

It is an unusually valuable handbook for students, interns or nurses.

D.A.B.

BODY AND MATURE BEHAVIOUR. A study of anxiety, sex, gravitation and learning. By M. Feldenkrais, London. 167 pages. Price $3.75. International Universities Press, New York City, 1950.

This small volume contains some thought-provoking ideas, and it should attract considerable attention today, since physicians are generally becoming more cognizant of the importance of psychosomatic factors in illness.

Several chapters are devoted to neurophysiology, with which most physicians are already familiar. The book points out the uniqueness of man, in that he is the only animal that assumes the erect position and requires a long period of parental tutelage before adapting himself to the forces of gravity and assuming an independent existence.

The main idea of the author is that carriage, posture and body movements have a certain influence on behaviour. He believes that a finer kinesthetic sense may be developed which will enable the individual to express his personality better.

The book should be of special interest to psychiatrists, neurologists and teachers of psychology.

D.A.B.

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BOOKS REVIEWED

HARVEY CUSHING: Surgeon, Author, Artist. By Elizabeth H. Thomson, research assistant at the Historical Library of Yale University School of Medicine. 347 pages, with 13 illustrations and 12 plates. Price $4.00. Henry Schuman, Inc., New York City, 1950.

This biography of Harvey Cushing is a shortened and popular work, written after the publication of the more exhaustive biography by Dr. John F. Fulton. The author, Miss Thomson, is research assistant at the Historical Library of Yale University School of Medicine, and had assisted Doctor Fulton in the preparation of his monumental account.

Having access to all of Doctor Fulton's sources, and others in addition, she has produced an exceedingly interesting and revealing story. In the foreword, Doctor Fulton describes the book as presenting Doctor Cushing and his surroundings in a little different light, and expresses the belief that the shorter biography will have a wider appeal than his own work.

Doctor Cushing was a man who made a written record, and many times also a pictorial record, of all of his doings. He was an inveterate letter writer, and kept a diary most of his life. From this wealth of material, all carefully preserved, have come two biographies, each from a different viewpoint, but both with a quality which leaves the reader with the feeling that he has come to know the subject as well as though he had worked with him.

PATTERNS OF PANIC. By Joost A. M. Meerloo, M.D., former member Netherland Red Cross Committee, instructor in psychiatry, Columbia University. 120 pages. Price $2.00. International Universities Press, Inc., New York City, 1950.

The author discusses panic from the descriptive standpoint, using experiences encountered during World War II as the illustrations for certain types and degrees of panic. The author stresses the importance of morale in the warding off of panic, stating that in future war civilian morale will decide if there is to be panic or not.

The author analyzes the postwar fears which have been accentuated further by the fear of the atomic bomb, as well as the hidden feelings of guilt which are especially experienced by the conqueror. The author cautions us to be realistic about the future; that there is no adequate defense against the atomic bomb. The only defense is the use of the same weapon and that means mutual suicide. The author feels that we need a new spiritual awakening; that we must recognize mankind's urge for catastrophe and suicidal tendencies and combat these urges.

In the last chapter the author discusses the three big musts of panic prevention—preparation, information, action.

The book is well written and is recommended for everyone who is interested in the various states of panic, as it not only illustrates these states but also stresses the hidden patterns found in panic.

M.F.G.

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BOOKS REVIEWED

A CENTURY OF MEDICINE IN JACKSONVILLE AND DUVAL COUNTY. By Webster Merrit, M.D., Jacksonville, Florida. 201 pages, with 46 illustrations. Price, $3.50. The University of Florida Press, Gainesville, Florida, 1949.

Many histories of state medical associations have appeared recently and the historians have had easy access to a rich source material from accumulated records. In the case of Florida, however, all records were destroyed by fire in 1901, and the author had the laborious task of seeking by the most accidental and indirect methods, to reconstruct the century's progress. After nearly every paragraph in the entire book is a citation, giving the exact source of the documentary evidence. The wide range of the bibliography attests the thoroughness of the work. Of unusual interest is the story of the battle against yellow fever, at a time when that scourge was a real threat to the United States.

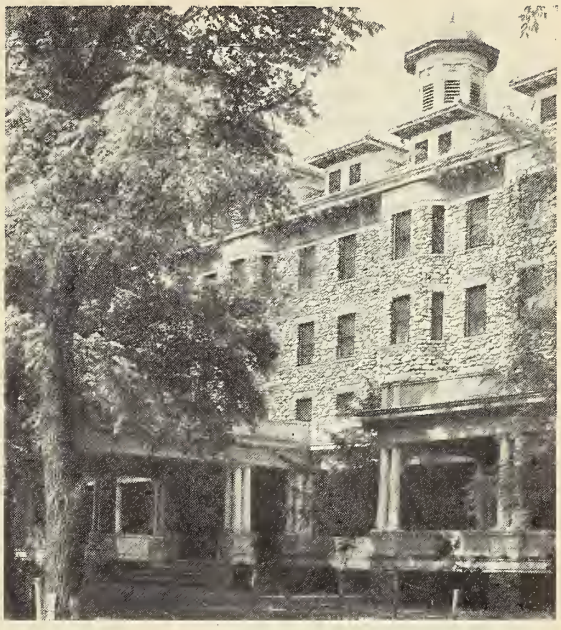
LIFE AMONG THE DOCTORS. By Paul de Kruif. 470 pages. Price $4.75. Cloth. Harcourt, Brace & Company, New York, 1949.

"Life Among the Doctors" is for the most part a fascinating report of some half dozen bold pioneers in various fields of medicine and medical economics. DeKruif's flair for dramatizing persons and events, his style of writing, his grasp of his subject, combine to make this book interesting reading for anyone.

This excellent report on these doctors whom the author regards so highly seems to have been inspired by a theory of his which he states early in the book: "The doctors will be as competent as we, the nondoctors, demand." The book is a running attack on the recent leadership of the A.M.A., on foundations controlling research grants, and on wide segments of the practicing profession. He frequently implies that failure of doctors generally to embrace the ideas of the men he writes about is because they believe their financial interests will be jeopardized, or at least that they do not bother to learn of them or to make use of them.

DeKruif is not infallible in his enthusiasms; thus this book stresses the 30-hour treatment of early syphilis, the necessity for heparin in the treatment of subacute bacterial endocarditis, his belief that large numbers of psychoneurotics and even psychotics are really treatable cases of avitaminosis, and the solution of about all medical problems through well-rounded group practice with prepayment. In his handling of the latter he ignores entirely the patients whose problems are basically psychosomatic. Indeed, doctors who think in terms of psychiatry will find little comfort in these pages.

This book will be widely read by laymen, and doctors cannot ignore it. Many of its statements will be, at least, irritating, but it must be said that they often hit the profession where it has made itself vulnerable, even though by the acts of a small minority. DeKruif's sponsorship of group practice and prepayment to combat the appeal of government medicine, to which he is definitely opposed, is sound, constructive thinking.



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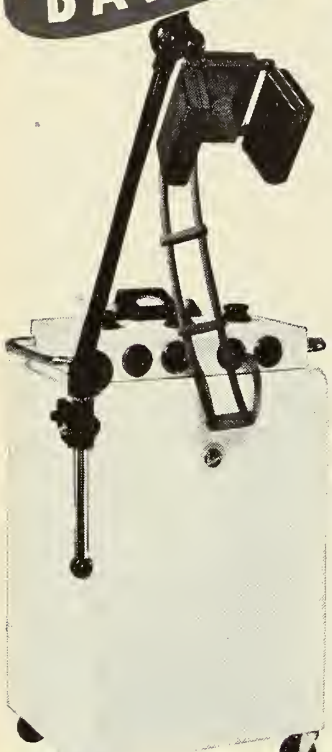

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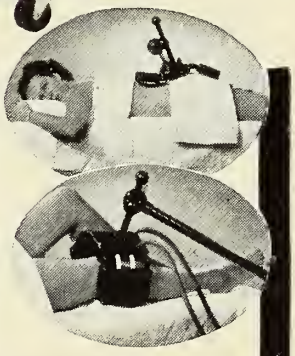

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BOOKS REVIEWED

PROCTOLOGY IN GENERAL PRACTICE. By J. Peerman Nesselrod, M.D., associate in surgery, Northwestern University Medical School. 276 pages with 64 figures. Price $6.00. W. B. Saunders Company, Phidalelphia, 1950.

This monograph of 276 pages is the type of book that should be of particular interest to the general practitioner. It is written by a man who has had extensive training in proctology under some of the ablest men in the profession. He has carried on exhaustive investigations on the embryology and anatomy of the pelvis in relation to the anorectum and sigmoid. It is an original book, incorporating the views of an able student. The results of his experiences in a large proctologic practice are set down in a readable and highly entertaining volume. The "Foreword" by Louis A. Buie, M.D., indicates the worth of this book.

The illustrations are excellent and the advice given is, in the main, very good. However it is a bit disconcerting to find a book published in 1950, advising a masterful do-nothing policy in acute thrombosed, prolapsing internal hemorrhoids. As long ago as 1937, 70% of the leading proctologists in this country advised prompt operation in this condition. Clotted blood is an excellent culture medium and should be removed. The only fatality of which I have read is that cited by Gabriel, in which an operation had not been done. The tenacity of life of a theory, based on a false premise, is indeed startling.

E. L. C.

MEDICAL MANAGEMENT OF GASTROINTESTINAL DISORDERS. By Garnett Cheney, M.D., clinical professor of medicine, Stanford University Medical School., 478 pages, with 29 figures. Price, $6.75. Year Book Publishers, Inc., Chicago, 1950.

This handbook is unusual in its discussion of gastrointestinal diseases from the standpoint of the patients' main complaints. The differential diagnosis discussed under each complaint shows the wide clinical experience of the author. This arrangement necessarily leads to some repetition which is obvious if the book is read straight through. The author's constant emphasis on the functional element in this group of diseases and its consideration in management is to be commended. Treatment is thoroughly discussed with detailed information on drugs and dosage. Several treatments are suggested in which the author has personal experience and which perhaps need more evaluation before presentation in this kind of book; namely, comparatively free diet in peptic ulcer with emphasis on large amounts of fresh vegetable juices and treatment of ulcerative colitis with Viodenum and Azopyran. In his discussion of colitis it might seem worth while to elaborate a little more on proctoscopic findings. He devotes considerable time to the selection of patients with acute appendicitis who might be better managed by antibiotics than by surgery; what he presents here seems sound to this reviewer. Bibliography is limited but most references are to very recent material. The book should prove valuable to all physicians except those intensively trained in gastroenterology.

S. L. J.

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—MAY 1950

Disease	May 1950	Apr. 1950	Mar. 1950	May 1949	May 1948
Brucellosis	2	1	2	2	11
Chickenpox	278	346	283	195	286
Conjunctivitis	7	12	12	7	0
Diphtheria	13	22	16	16	55
Encephalitis	1	3	2	5	3
Erysipelas	1	0	1	4	2
Food Infection	3	0	3	1	0
Impetigo	3	0	0	3	1
Influenza	6	37	113	0	2
Infectious hepatitis	1	5	0	0	0
Measles	2244	1733	1112	596	3920
Meningitis,					
Unclassified	2	4	6	4	5
Influenzal	1	1	1	0	0
Meningococcal	4	10	3	2	2
Pneumococcal	2	0	1	1	0
Mumps	125	132	195	173	565
Pneumonia	20	122	71	16	22
Poliomyelitis	3	2	4	2	6
Rabies, animal	52	70	30	94	142
Rocky Mt. Spotted fever	1	0	0	2	1
Rubella	83	58	79	425	76
Scabies	2	0	0	0	1
Scarlet fever	170	268	326	132	170
Tetanus	2	1	1	1	3
Tinea capitis	21	0	0	0	34
Tuberculosis,					
Pulmonary	206	288	175	208	238
Other forms	30	14	17	11	19
Typhoid fever	1	1	2	3	4
Whooping cough	176	188	151	47	99
Psittacosis	1	0	0	0	0

MONTHLY REPORT—JUNE, 1950

Disease	June 1950	May 1950	April 1950	June 1949	June 1948
Brucellosis	6	2	1	6	8
Chickenpox	131	278	346	94	134
Diphtheria	4	13	22	19	22
Dysentery, bacillary	1	0	0	0	2
Encephalitis	4	1	3	2	3
Food poisoning	9	3	0	1	0
Measles	1167	2244	1733	545	1639
Meningitis,					
Unclassified	1	2	4	3	5
Influenzal	2	1	1	0	0
Streptococcal	1	0	0	0	0
Meningococcal	3	4	10	3	6
Meningococcemia	1	0	1	0	0
Mumps	74	125	132	99	222
Pneumonia	25	20	122	16	26
Poliomyelitis	5	3	2	10	12
Rabies in animals	62	52	70	62	65
Rocky Mt. spotted fever	3	1	0	2	6
Rubella	39	83	58	107	23
Scarlet fever	47	170	268	59	103
Tuberculosis,					
Pulmonary	174	206	288	181	244
Other forms	15	30	14	15	15
Typhoid fever	4	1	1	4	5
Vincent's angina	1	0	2	1	0
Whooping cough	137	176	188	81	25
Tinea capitis	3	21	0	0	17

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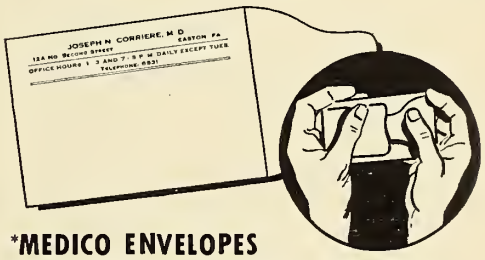

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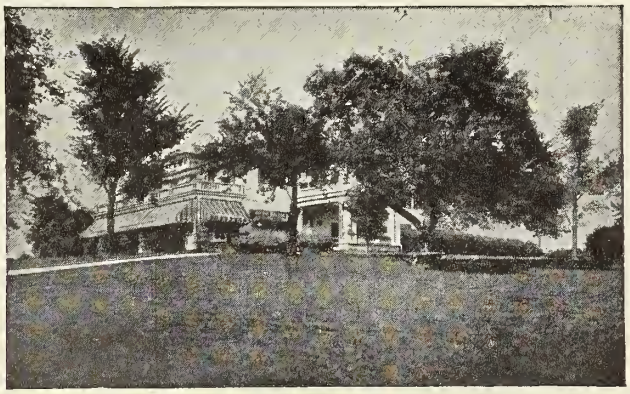

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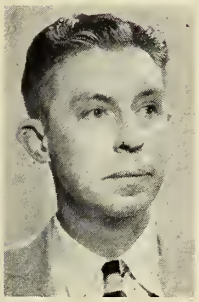
VOLUME 43 SEPTEMBER, 1950 NUMBER 9

THE DIAGNOSIS OF INTRACRANIAL TUMOR*

S. R. SNODGRASS, M.D.

GALVESTON, TEXAS



The Author:

Doctor Snodgrass is a native of Franklin, Indiana, and is a graduate of Indiana University School of Medicine, in 1929. He spent his internship at Indianapolis General Hospital and at Lakeside Hospital, in Cleveland. He was resident in pathology at Indiana University Medical Center, and assistant resident surgeon at Peter Bent Brigham Hospital, in Boston. He had a fellowship in neurological surgery at Washington University in St. Louis, and a fellowship in clinical neurology at National Hospital, Queen's Square, London, England. He holds membership in the American Academy of Neurological Surgery and the Harvey Cushing Society. Doctor Snodgrass is at present associate professor in charge of neurosurgery, at the Medical Branch of the University of Texas, in Galveston.

IN THE interval since the first World War, neurosurgery has won acceptance as a specialty, and its practitioners now number approximately 500. Although the scope of neurosurgery has broadened notably by the addition of sympathectomy, herniated intervertebral disk lesions and psychosurgery, its primary concern remains in the treatment of intracranial tumors. During these years the tendency of certain neoplasms to occur at certain anatomical sites and at certain ages has been established, and the pathology of intracranial tumors has been related accurately to their clinical behavior. Often the pathological nature of the neoplasm may be accurately predicted before operation. The syndrome of chronic subdural hematoma following head injury has become well understood. More effective methods in the control of brain abscess have been worked out. Progress in the diagnosis and treatment of intracranial aneurysms is being made. Special diagnostic techniques have been developed which establish the presence of intracranial tumors with an accuracy approaching 100 percent. Improvements in the operative management of these patients have reduced the operative mortality to a figure not usually exceeding 10 or 15 percent, and in certain groups of benign tumors the operative mortality is consistently less than 5 percent.

Unfortunately, survival of operation is not synonymous with cure for, as in other parts of the body, malignant tumors are frequently encountered which inevitably recur locally, in spite of apparently complete removal. The neurosurgeon, probably even more than his colleagues operating upon neoplasms elsewhere in the body, urgently needs additional methods of therapy, for probably not more than 30 to 40 percent of patients with

* Presented at the centennial session of the Indiana State Medical Association, at Indianapolis, on September 28, 1949.

intracranial tumors are curable by means now available.[1] Results of treatment of patients with intracranial neoplasms are, however, better than is generally recognized. In patients surviving operation the ten-year survival compares favorably with those operated upon for cancer of the breast.[1] In the past a high operative mortality. and the difficulty of access to neurosurgeons may have tended to delay investigation of patients suspected of intracranial tumor until treatment could be postponed no longer. Such a policy is no longer justified, and undue delay in instituting treatment increases the operative mortality. With neurosurgeons now available in most cities. general practitioners have become more aware of intracranial tumors, and a much larger number of patients receive treatment than in the past. Although there has been great improvement in the recognition of intracranial tumors, neurosurgeons so frequently see patients in whom the diagnosis has been unduly delayed that one suspects the general practitioner considers this diagnosis only after excluding everything else. This attitude may be caused in part by the relative infrequency of brain tumor and in part by inadequacies in the history and examination of these patients.

Probably more important than these is the lack of a systematic consideration of the possibility of intracranial tumor.[2] As related in a recent article[3] dealing with delays and errors in the diagnosis of intracranial tumor, 100 patients with intracranial neoplasms chosen at random treated at Yale University School of Medicine had the correct diagnosis made in only four instances by general practitioners and such a diagnosis was suspected in only two additional cases. In twenty patients the idea was expressed that there was nothing wrong with the patient, and in twelve additional cases the patient was suspected of having a neurosis. In almost half the patients the correct diagnosis was delayed for more than one year. Ninety-four of these patients were examined by neuropsychiatrists or neurosurgeons, and the correct diagnosis was made in eighty-seven. While I do not believe this report is representative of the performance of general practitioners as I have seen them, it shows a lack of familiarity with the manifestations of brain tumor and emphasizes a need for further educational efforts. I wish therefore to present a brief, elementary discussion of the manifestations of intracranial tumor which will give positive information to suggest this condition. Suggestions as to appropriate diagnostic studies will be made. No claim for originality is advanced for any portion of this discussion.

Intracranial tumors manifest themselves in one or more of three different ways: by the production of convulsive attacks, by the development of a progressive focal neurologic disturbance, or by producing signs or symptoms of increased intracranial pressure.

CONVULSIVE ATTACKS

Convulsive attacks caused by birth injury or by developmental abnormalities of the brain usually appear in infancy. Attacks due to idiopathic epilepsy as a rule manifest themselves before or at the age of puberty. Convulsive attacks beginning in adult life should be considered as symptomatic of organic brain disease until such is proven otherwise. In adults developing convulsive attacks for the first time, neurosyphilis, trauma to the head, occlusive vascular disease and intracranial tumor are approximately equal as causative factors.[4] Neurosyphilis may be readily detected by serological studies of the blood and spinal fluid. Trauma to the head rarely causes convulsive attacks unless the trauma has been sufficiently severe to tear the dura and to produce a definite scar in the brain. Convulsions should not, therefore, be attributed to head injury unless the injury has been of a definitely major character. Occlusive vascular disease is rarely the cause of convulsive attacks in young adults, and in middle-aged or elderly patients caution is desirable in attributing convulsive attacks to such a presumed disorder. It has long been recognized that convulsive attacks are common in patients with intracranial tumors. Reported series of intracranial neoplasms show an incidence of convulsive seizures ranging from 20[5] to 37[6] percent, with the higher figure probably being the more accurate. Convulsive attacks occur predominantly in patients with neoplasms involving the cerebral hemispheres and are rare with tumors elsewhere.

The incidence of convulsive attacks in patients with cerebral tumor depends in part upon the duration of the disease, with attacks more frequently encountered with slowly-growing tumors. The closer the situation of the tumor to the motor area, the higher the incidence of attacks. Although all attacks caused by intracranial tumor are focal or Jacksonian in the sense that they originate in a particular area, in only approximately one-third of the patients is it possible to recognize the focal character of the attack. A focal attack always begins in the same way and involves a portion of the body by a sensory or motor disturbance or it may involve one of the special senses. Frequently an adequate description of the attacks is not available. In approximately 30 percent of patients experiencing seizures, the attacks are the first indication of the tumor. These attacks may precede by as long as 20 years[5] subsequent manifestations of tumor. All adults experiencing convulsive attacks for the first time should, therefore, be carefully investigated as to the possibilities of intracranial tumor.

PROGRESSIVE FOCAL DISTURBANCE

The tendency for progressive growth is perhaps the most characteristic feature of neoplasms. If a neoplasm occurs in a portion of the brain where it produces a recognizable focal neurologic disturbance, this tendency to increase in size produces a progressive increase in the neurologic disturbance. Among the most commonly encountered syndromes of this type is the development of hemiparesis which had begun with an isolated weakness of the face, the arm or the leg, but which subsequently comes to involve all three. Progressive aphasic difficulties are common. Perhaps the most characteristic neurologic disturbance of this type is the bitemporal hemianopsia which develops when the optic chiasm is compressed by a pituitary adenoma. In the middle-aged or elderly patients there is a tendency to attribute these neurologic disturbances to vascular disease. Following vascular occlusion usually there is immediately a maximal neurologic involvement with subsequent gradual improvement; this bears only a superficial resemblance to the progressive neurologic disturbance seen with tumor. Intracranial tumors should therefore be carefully considered as a diagnostic possibility in all patients in whom a single neurologic lesion exists when it is of a progressive nature.

SIGNS OF INTRACRANIAL PRESSURE

Headache, vomiting and failing vision, the symptoms of increased intracranial pressure, occur in intracranial tumor only when the tumor has reached sufficient size to interfere seriously with the intracranial physiology. Although such symptoms may be the earliest manifestation of a tumor, they are evidences of a far-advanced condition which already menaces the patient's further survival.

Headache produced by intracranial tumor is usually of a generalized nature, although at times its intensity is greatest in the frontal or fronto-temporale region. Often lesions in the cerebellum produce headache which is experienced in the back of the head and neck. Localized headache, while uncommon, usually indicates the lesion is on the painful side. Headache awakening the patient in the morning or occurring shortly thereafter is particularly suggestive of intracranial tumor. Headache usually subsides in a few minutes to a few hours, and continuous headache is not to be expected. Headache is usually severe and occurs with increasing frequency. It usually responds poorly to home remedies and medication, and during the presence of the headache the patient frequently lies down and, as a rule, is unable to continue his customary activities.

Vomiting occurs in most patients experiencing severe headache caused by intracranial tumor. Vomiting is usually preceded by nausea and tends to occur at the height of the headache. Projectile vomiting, contrary to the idea often advanced, is infrequent. As a rule, there is nothing characteristic about the vomiting, with the possible exception that frequently the nausea does not persist and the patient is willing to eat shortly after having vomited. Vomiting may occur in the absence of nausea or headache, especially in tumors involving the brain stem. Repeated vomiting not explained by other cause should always suggest the possibility of brain tumor.

Approximately half of the patients with intracranial tumor show papilledema or "choked disks" at the time of the first examination. This condition is an expression of a general increase in the intracranial pressure; when it exists in high degree for any great length of time, secondary optic atrophy and failing vision occur. This may progress to blindness and is not improved by subsequent lowering of the intracranial pressure to normal. Ninety percent of patients showing papilledema have intracranial tumor, and its detection should lead to prompt investigation to confirm or eliminate that condition. The tendency of physicians to discontinue the use of the ophthalmoscope on account of the infrequency of positive findings greatly delays the recognition of many intracranial tumors. A physician not confident of his ability to recognize papilledema owes his patients with recurring severe headache referral for ophthalmological examination. Patients with increased intracranial pressure, particularly that developing rapidly, often show an increased tendency to sleep, and in the latter course of their disease they become stuporous or semicomatose. The development of stupor or coma is an urgent indication for the completion of studies leading to a definite diagnosis. Such patients with tumor have a low margin of safety for operation, and their survival for any length of time without operation is improbable. Changes in the pulse rate and blood pressure are not to be expected with the increased intracranial pressure accompanying tumor.

SYSTEMATIC INVESTIGATION

Investigation of patients suspected of intracranial tumor should be carried out in a thorough, systematic fashion. A thorough history is particularly desirable, especially in regard to the description of convulsive phenomena and in the manner of development of neurologic disturbances. Approximately 10 percent of intracranial tumors are metastatic in origin, and systematic inquiry for disease involving other systems of the body is in order, together with inquiry concerning previous operative procedures for neoplasm. A thorough physical examination is of great value, and it is not unusual in metastatic lesions for physical examination to disclose a primary growth

or evidence of extracranial metastatic lesions. X-ray examination of the chest is desirable in all patients and is particularly indicated in those with a rapid progression of the clinical picture. Neurologic examination is of great value and suffices to localize the majority of intracranial tumors.

The average practitioner, never too secure in his knowledge of neuroanatomy, becomes less so with the passage of time. He distrusts his neurologic findings and finds difficulty in their interpretation. On account of the infrequency of positive findings, he tends to neglect this feature of his examination. Neurologic examination must be carried out in a methodical fashion, otherwise important portions are likely to be unintentionally omitted. Examination should begin with notations concerning the patient's speech, memory and orientation, which have been observed to at least some degree during the interview required for history-taking. Next, the scalp and skull should be noted for palpable masses and bony abnormalities, and nuchal rigidity sought. The cranial nerves should then be examined in numerical order. Visual acuity, ophthalmoscopic appearance of the fundi, the visual fields (as tested by hand movements on confrontation), pupillary equality and reaction and ocular movements, especially as to the presence or absence of nystagmus, must be carefully observed. Facial weakness should be noted, together with sensory disturbances upon the face. The remaining cranial nerves are less commonly involved by intracranial tumor, but their examination should not be omitted. Ataxia, motor power, sensation and reflexes in the upper and lower extremities should be tested. Disturbances of gait must not be overlooked. Differences in the reflexes upon the two sides, or the presence of an extensor plantar response, indicate the presence of a definite, organic neurologic disorder.

Thorough laboratory examination of patients suspected of intracranial tumor is of great importance. Studies of the patient's blood and urine are desirable. Intracranial tumor and syphilis may at times coexist, and one must not persist in attributing symptoms or findings to syphilis if they progress during treatment. Lumbar puncture frequently shows abnormalities of the cerebrospinal fluid in patients with intracranial tumor, although these are rarely of fundamental importance in establishing this diagnosis. When papilledema is present it is a better index of increased intracranial pressure than is a manometric reading. If papilledema exists, lumbar puncture should be omitted on account of the danger of cerebral herniation associated with the removal of fluid. The chief value of lumbar puncture is the disclosure of positive findings which establish an alternative diagnosis.

X-ray films of the skull are of value in all patients suspected of tumor. Plain films show calcification in the lesion itself in 10 to 15 percent of the cases, and in more than 60 percent positive findings suggesting tumor exist.[7] Tumor may produce either localized thinning or thickening in the overlying skull or there may be increased vascularity of the skull in the region of the tumor. The pineal gland is calcified sufficiently to be visible in x-ray in approximately two-thirds of adults. Its displacement, especially in a lateral direction, establishes the diagnosis of tumor. A general increase in the intracranial pressure may be indicated by increased convolutional markings on the inner table of the skull or by decalcification or enlargement of the sella turcica. These bony changes require several months for their development.

Electroencephalography has been of great value in the study of patients suspected of intracranial tumor. Localized abnormalities are often present in the record and, taken in conjunction with the clinical picture, are frequently diagnostic. On account of its ease of application and its lack of danger, electroencephalography should be utilized in all patients suspected of intracranial tumor.

Special studies (pneumoencephalography, pneumoventriculography, and cerebral arteriography) are of great value. If indicated, the use of the appropriate one of these procedures will establish the presence and localization of tumor in more than 95 percent of cases. On account of its relative freedom from dangerous complications, the use of cerebral arteriography is increasing. It is frequently possible from such examination to predict the histologic nature of the tumor. This information may be of value in the choice of operation made. Encephalography and ventriculography, by which the cerebral ventricles are filled with air or gas, should be utilized only by specialists on account of the danger of precipitating changes necessitating immediate operation; operation is best performed immediately after these studies are completed.

SUMMARY

Intracranial tumor should be suspected in those patients who begin to experience convulsive attacks in adult life, those who show the presence of a progressive focal neurologic disturbance, or those who show signs and symptoms of increased intracranial pressure. Appropriate studies will establish the diagnosis with a high degree of accuracy. The early referral of these patients to neuropsychiatrists or neurosurgeons will improve the results of surgical treatment and further diminish the operative mortality.

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THE TREATMENT OF ARTHRITIS*

HOWARD C. COGGESHALL, M.D.

DALLAS, TEXAS

The Author:

Doctor Coggeshall attended DePauw and Indiana Universities, receiving his M.D. degree in 1932. He served as a Research Fellow in the Lilly Laboratory at Indianapolis General Hospital. He spent one year at Yale Medical School, in psychiatry, one year at Harvard Neurological Unit at Boston City Hospital, and seven years as a member of the Harvard Medical School Faculty at the Massachusetts General Hospital. During World War II he was a member of the Army Medical Corps as Assistant Chief of the Army Rheumatism Center, Army and Navy General Hospital, Hot Springs, Arkansas. He is a Fellow of the American College of Physicians, American Rheumatism Association, founder and first president of the Texas Rheumatism Association. He is now assistant professor of Clinical Medicine at Southwestern Medical School of the University of Texas, and a member of the W. B. Carrell Clinic, of Dallas, Texas.

IN VIEW of recent developments indicating that the symptoms of rheumatoid arthritis and other types of mesenchymal disease can be reversed at will by the administration of cortisone and adrenocorticotropic hormone of the anterior pituitary gland (ACTH), we must be prepared to make far-reaching changes in our concept of these diseases.[1] This development has brought a renewed interest in the chronic rheumatic diseases, which constitute the largest group of diseases lacking a proper etiological explanation. It seems timely to review some of the basic concepts regarding the diagnosis and treatment of arthritis and rheumatic disease.

Before proceeding to the discussion of therapy attention should be called to the great variety of conditions which give rise to joint symptoms. In the lay mind the term arthritis or rheumatism usually includes diseases of the neuromuscular systems. Therefore, the first step in therapy is to define the nature of the disability. Once the physician has arrived at a working diagnosis he can give the patient an acceptable explanation for his disability and set forth on a program of treatment. Until we have a better understanding of the underlying pathological physiology of articular structures, a great many therapeutic procedures must be supportive. Even though these measures are nonspecific, they are important in minimizing the number of arthritic cripples. Specific chemotherapeutic agents are available for the treatment of septic arthritis. In this instance, with the exception of tuberculosis arthritis, destruction of the joint may be prevented by proper chemotherapy during the first two weeks of the infection. Even though the use of sulfonamide drugs, penicillin, and other antibiotics has caused a marked decline in the incidence of gonococcal arthritis, it remains the most frequent type of specific infectious arthritis encountered in young adults. The efficacy of chemotherapy in preventing joint destruction depends upon an early diagnosis proved by the isolation of the causative organism from the synovial fluid.

A simple classification of arthritis based upon the report of the committee on classification of

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the American Rheumatism Association[2, 3] is set forth in Table I. This classification divides the various types of arthritis according to etiology. The most important advance made in this classification is the acceptance of the term rheumatoid arthritis and the discontinuation of a variety of others, including atrophic, proliferative, and chronic infectious arthritis. Degenerative joint disease has been introduced to set apart the large group having articular symptoms which occur as a part of the aging process. The term degenerative joint disease should be used instead of osteoarthritis and hypertrophic arthritis.

TABLE I

CLASSIFICATION OF JOINT DISEASE[2, 3]

A. Joint Disease of Known Etiology:
   1. Traumatic—secondary to injury.
   2. Specific infectious—septic positive culture from joint.
   3. Neuropathic—tabes, syringomyelia.
   4. Metabolic—gouty arthritis.
   5. Constitutional—hemophilia.
   6. Anaphylactic—serum sickness.

B. Joint Disease of Unknown Etiology:
   1. Degenerative joint disease (osteoarthritis).
      a. Primary—generalized, secondary to the wear and tear and aging of articular cartilage.
      b. Secondary—occupational trauma, healed infections, fractures, etc.
   2. Rheumatoid arthritis (atrophic).
      a. Typical—insidious, progressive, symmetrical.
      b. Atypical—acute, asymmetrical, "focal."
      c. Spondylitis—(Strumpell-Marie)
         (1) Pure—without peripheral joints.
         (2) Combined.
      d. Juvenile—(Still's fever)
   3. Rheumatic fever.
   4. New growths of joints.
   5. Hydroarthrosis, intermittent (probably a form of rheumatoid).
   6. Periarticular fibrositis.
   7. Palindromic rheumatism (probably a form of rheumatoid).
   8. Psychogenic rheumatism (symptom of psychoneurosis).
   9. Reiter's disease (probable cause, pleuro-pneumonia organism).

C. Diseases with Which Arthritis is Frequently Associated:
   Acromegaly
   Acute disseminated lupus erythematosus
   Cyst of meniscus of knee
   Dermatomyositis
   Drug intoxication
   Erythema nodosum
   Erythema multiforme exudativum
   Hyperparathyroidism
   Hysteria
   Ochronosis
   Osteochondritis dissecans
   Osteochondromatosis
   Paget's disease
   Periarteritis nodosa
   Psoriasis
   Pulmonary osteoarthropathy
   Raynaud's disease
   Senile osteoporosis
   Scleroderma
   Subacute bacterial endocarditis

The following remarks will be confined to the two major types of arthritis: (1) Degenerative Joint Disease (osteoarthritis), and (2) Rheumatoid Arthritis.

DEGENERATIVE JOINT DISEASE

Degenerative joint disease[4] results from the progressive degenerative changes in the articular cartilage which makes its appearance at about the age of 40 years. Examination of the knee joints will show varying degrees of involvement in all individuals in excess of 60 years. Much of this wearing out of the articular cartilage can be explained by its inability to regenerate and repair defects that arise from the trauma of constant daily "wear and tear." This process may be entirely painless until the poor alignment of the joint-bearing surfaces causes additional stress upon the ligamentous marginal structures. This unaccustomed pull upon the joint capsule and its ligamentous structures at the cartilagenous-osseous-periosteal-synovial junction is responsible for the pain. The osteophytes which appear at this site are secondary to long continued trauma to the periosteum. Histological examination of the synovial membrane and synovial fluid shows little if any evidence of inflammation. There is no evidence that infection plays any role in the etiology of degenerative joint disease.

The diagnosis and treatment of degenerative joint disease is simplified if one has a clear picture of the underlying pathology. One can visualize an obese, middle-aged woman who complains of painful knees while in motion. She has never been sick in her life and feels fine as long as she is not in motion. All laboratory examinations are normal except for the roentgenograms.

Treatment of degenerative joint disease should consist of reassuring the patients that they do not have a crippling disease and that proper treatment will bring gratifying results. The patients should be instructed in the use of salicylates, home physical therapy methods and how to reduce weight. These measures are adequate in most instances; a few may require surgical treatment.

Before leaving the subject of degenerative joint disease a few remarks should be made concerning the Heberden's nodule. Frequently these deformities are the reason for the patient's seeking medical advice. It is important to reassure such an individual that he is not suffering from the first symptoms of a generalized arthritis. Recent observation by Stecher on 7,000 individuals having these nodes reveals a high familial incidence.[5] This lesion is not accompanied with a greater incidence of arthritis in other joints.

RHEUMATOID ARTHRITIS

The treatment of rheumatoid arthritis is difficult because of its unknown etiology. For the last twenty years considerable emphasis has been placed on its possible relationship with an infec-

tious process. Too much attention has been focused on the search and removal of focal infections. The approach of study and therapy with vaccines has been unproductive.

The primary pathological lesion of rheumatoid arthritis is to be found in the synovial membrane. Examination of this connective tissue membrane shows hyperemia, edema and a heavy infiltration of inflammatory cells. In many instances there is an increase of joint fluid which has the characteristics of an exudate. As the disease progresses, the synovium forms a pannus which grows into the margin of the joint and destroys the articular cartilage and results in adhesions, joint destruction and finally ankylosis.

One can visualize the typical patient with rheumatoid arthritis as one who complains of morning stiffness, anorexia, weight loss, fatigability and emotional depression. The physical examination reveals symmetrical involvement of joints, especially the interphalangeal joints of the hands and feet, muscle atrophy, lymphadenopathy, and cold, clammy hands and feet. The synovial membrane will be thickened and even the small joints may contain an excess of fluid. The laboratory findings may show only an elevated sedimentation rate.

Spontaneous remission of rheumatoid arthritis without apparent cause was observed by Garrod in 1876. Hench has recently reviewed this subject and observed that a number of conditions may result in a remission which will last for months, years, or even a lifetime.[6] Among these conditions which provoke a reversibility are: pregnancy 90 percent, juandice 83 percent, gold salts 15 percent, and general supportive care 15 percent. A favorable response may be produced occasionally by artificial fever, the injection of foreign proteins, starvation, surgical procedures, anesthesia and blood transfusions. Such observations have stimulated considerable thought as to the possible metabolic background of this disease. Investigations made along these lines by Drs. Hench, Kendall, Slocumb and Polley have resulted in the introduction of the hormones cortisone (compound E) and ACTH. These experimental tools control the symptoms of rheumatoid arthritis, rheumatic fever, acute disseminated lupus erythematosus and other diseases of the mesenchymal system.

The large amounts of cortisone required suggest that it may not be the final product, but merely one which must undergo further metabolic transformation after its administration. Is it possible for such a small structure as the adrenal cortex to manufacture 100 to 300 mg. of this hormone daily? There is already at hand evidence that other steroids (testosterone propionate, pregneninolone, and progesterone) given to patients with rheumatoid arthritis in comparable doses may give a favorable response, but not in the same magnitude as observed with cortisone.[7] The use of the sex hormones in large doses is dangerous, experimental, expensive, and would not seem practical for continued therapy. This point is mentioned to emphasize that a better steroid than cortisone may be in prospect.

One cannot overestimate the contribution of Drs. Hench and Kendall et al, because they had the foresight and initiative to introduce a new antirheumatic agent. For the first time we have at hand an experimental aid which is capable of controlling the symptoms of the various rheumatic diseases affecting the mesenchymal system.

CONCLUSION

Until these antirheumatic steroids are available at some future time, we are faced with the problem of treatment without the aid of the "ten magic drops." Many physicians have been suddenly forced by their arthritic patients to interest themselves in rheumatology. One must be prepared to rely on supportive therapy, consisting of the regular use of salicylates, physiotherapy, sedatives and rest. Anemia should be combated by whole blood transfusions and iron preparations. Vitamins in excess of the daily requirements are contraindicated. No dietary restrictions should be imposed and the patient should be encouraged to keep on a high caloric and vitamin regimen. Marked joint deformity and crippling can be prevented if the patient has the benefit of the advice of an orthopedic surgeon. The proper treatment of the arthritic is a combination of medical, psychiatric and orthopedic care.

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PERFORATIVE APPENDICITIS COMPLICATING THE PREGNANCY OF A WOMAN WITH SITUS TRANSVERSUS VISCERUM

Case Report

Norman F. Richard, M.D.

SHELBYVILLE

COMPLETE transposition of the abdominal and thoracic viscera is a relatively infrequent condition. When this anomaly is accompanied by pregnancy and is further complicated by a perforative appendicitis, it becomes extremely rare; in fact I have been unable to find a similar event recorded in medical literature.

Available statistics give the incidence of complete transposition to lie somewhere between .01 percent[1] and .07 percent[2] with an average of .0315 percent. Sherk[3] at the Mayo Clinic in 1922 reported 10 cases in 347,000 admissions; Willis[4] in 1925, 3 in 10,000; Adams and Churchill[1] in 1937, 23 in 232,112 at the Massachusetts General Hospital. In 1925 LeWald[2] discovered the condition in 29 of 40,000 x-ray studies. Cleveland,[5] reviewing the literature in 1926 found 400 examples, while Rosler[6] in 1930 noted transposition of the viscera 3 times in 22,402 autopsies. By 1938 Larson[7] was able to collect 475 cases.

Appendicitis in pregnancy is a rather frequent happening, Mussey and Crane[8] giving its incidence as 2 percent and Paddock[9] 2.5 percent.

Regarding acute appendicitis associated with complete transposition of the viscera, Byrd C. Willis[4] reviewed the literature in 1925 and found 15 reported instances. Since that time approximately 55 cases have been added.

Fabricius[10] in 1600 A.D. was the first to report transposition of the viscera in man; however, Aristotle previously had observed two cases in animals. In 1615 Petrius Servius[3] recorded an instance discovered at autopsy. In 1824 Kreichenmeister[8] made the diagnosis in a living patient. Vehsemeyer[11] in 1897 is credited with being the first to discover visceral transposition by means of x-ray studies.

A review of the literature reveals that about 70 cases of appendicitis in complete transposition of viscera have been recorded between the years 1883 and 1948. Doubtless many more have been encountered but not reported, such as one met by Harold D. Caylor. Strangely enough, not a single instance of perforated appendix in situs transversus viscerum has been described in a pregnant woman. Because of the rarity of this double complication of pregnancy, it seems worth-while to report a case treated recently by the author.

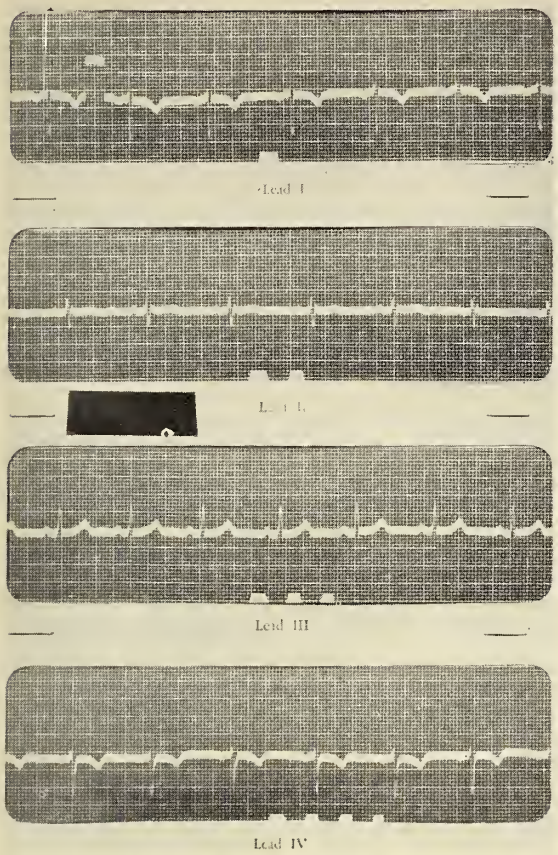
CASE REPORT

The patient, a white, married woman, aged 26, five months pregnant, was first seen by the writer the morning of October 4, 1946, when she was referred to the W. S. Major Hospital by her family physician because of severe lower abdominal distress. She had been delivered of a full-term normal male infant four years previously. Her last menstrual period had occurred in April, 1946. In January, 1946, she had sought the aid of a physician because of pain in the right lower abdominal quadrant. A diagnosis of a mild attack of appendicitis was made. Within a few days the patient recovered. There had been no subsequent complaint between that time and the onset of the present illness. On September 28, 1946, the patient became ill with nausea and vomiting, and epigastric distress. Forty-eight hours later the pain having moved into the lower abdomen, she summoned the services of her family physician who found what he described as a mass in the left lower abdominal quadrant. The vomiting continued, accompanied by a slight fever, but there were no chills. Since the pain was almost entirely on the left side and the vomiting attributed to the pregnancy, the physician was not unduly alarmed until his next visit to her home the morning of October 4. At this time it was obvious that her condition was much worse, the protracted vomiting and generalized lower abdominal pain making it advisable that she be sent at once to the hospital.

Upon admission she stated that she had not felt fetal movement for the previous twelve hours and that she had had no labor pains. Her oral temperature was 102.6° F., the pulse rate 120 per minute, and the blood pressure 120/80. Her face was flushed, with sordes present about the lips and teeth. Peritoneal facies was evident.

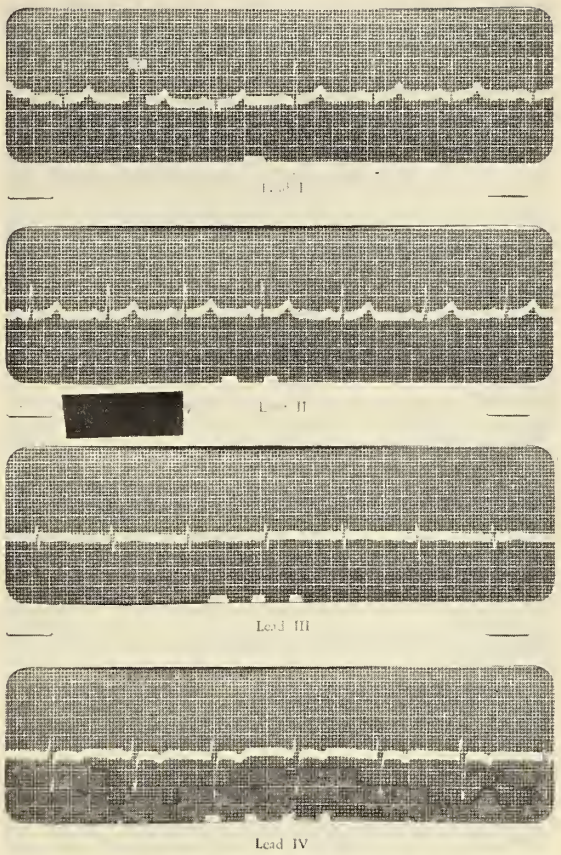
Examination of the head and neck revealed a congenital coloboma of the left eye. The lungs were normal to percussion and auscultation. Examination of the heart revealed the point of maximum impulse to lie in the fifth interspace in the midclavicular line on the *right* side. Percussion disclosed that the liver dullness was on the left. The abdomen was enlarged to approximately the size of a pregnancy of five months. No fetal heart

Figure 1.



Electrocardiogram taken in usual manner showing mirror-image reversal of the normal pattern.

Figure 2.



"Normal" electrocardiogram produced by reversal of arm leads.

sounds could be heard. There was generalized tenderness with rigidity over the entire lower abdomen, more marked on the left. No mass could be felt in the left lower abdominal quadrant. Rovsing's sign and rebound tenderness were absent. Pelvic examination except for verification of the size of the uterus was noninforming.

A white blood count performed at 9:00 A.M. the day of admission revealed 6,800 cells per cubic millimeter, 90 percent of which were polymorphonuclear.

Intravenous infusion of 5 percent glucose in isotonic saline solution was started and the patient given 30,000 units of penicillin intramuscularly every three hours. She was observed carefully and at 7:00 P.M. the same day another white blood count was performed which revealed 11,300 cells per cubic millimeter, of which 84 percent were polymorphonuclear in type. Because of the serious condition of the patient no roentgenograms were taken.

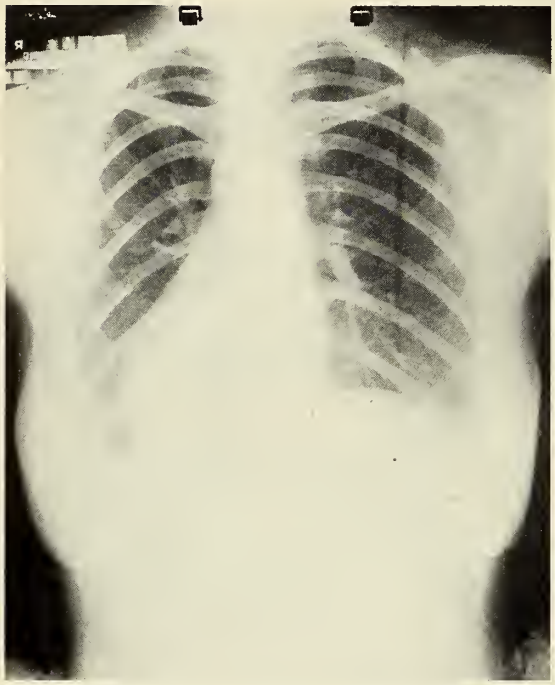
A preoperative diagnosis was made of a perforated left-sided appendix with localized peritonitis and pregnancy at five months with probable fetal death. Situs transversus viscerum was obvious because of the dextrocardia and the location of liver dullness on the left side.

OPERATION

Under cyclopropane-ether anesthesia the abdomen was opened through a left paramedian incision. The uterus was enlarged to approximately the size of a five month gestation and no fetal movement was noted within. A considerable amount of foul-smelling, seropurulent fluid was encountered. The cecum and appendix were found lying on the left side with both structures adherent to the left tube and ovary and to the parietal peritoneum. The cecum was mobilized somewhat and a gangrenous perforated appendix removed. One soft rubber and two Penrose drains were brought out through a stab wound in the left flank, and five grams of sulfathiazole were placed in the abdomen before closure of the incision with interrupted sutures of chromic 0 catgut. The skin edges were approximated with interrupted sutures of cotton No. 24. The abdomen was not explored because of the severe infection present.

Upon her return from the operating room, Wangensteen suction was instituted immediately and intravenous fluids administered. Intramuscular in-

Figure 3.



Roentgenogram of chest revealing dextrocardia.

Figure 4.

Roentgenogram of colon illustrating position of cecum on left side.

jections of penicillin were continued at the rate of 30,000 units every three hours. Five milligrams of progesterone in oil were given daily.

On the second postoperative day the patient began to have moderate vaginal bleeding, and three days later with the help of light cyclopropane anesthesia was delivered of a stillborn, five-months-old fetus. She left the hospital on the thirteenth postoperative day in good condition.

One month after her operation, at the writer's request, she reported to the clinic for electrocardiographic and gastrointestinal x-ray studies.

The electrocardiographic interpretation was: "mirror image dextrocardia"; the report of the roentgenologist as follows:

"Fluoroscopy shows the lung fields to be normal. The heart is reversed, the apex and aortic knob being on the right side. The size of the heart appears normal. There is a gastric air bubble beneath the right diaphragmatic leaf and the liver density is on the left. The esophagus is posterior to the aortic arch. The stomach and the duodenum are reversed in position but otherwise appear normal. Six hour observation shows the stomach to be empty with most of the barium meal in the colon. The latter is reversed, the cecum lying in the left flank."

Until the third month of fetal life the cecum and appendix normally lie in the left side of the abdomen, the ileum entering the large bowel from right to left. About this time the cecum begins to ascend, crosses the duodenum in the upper abdomen, and then descends to come to rest in the right lower quadrant. While this change is occurring the large bowel also rotates upon its long axis so that the ileum finally enters the cecum from left to right. Lee[12] describes this as a "fan-like movement." Should the migration of the cecum be incomplete, as sometimes happens, the appendix may come to lie in any of the abnormal positions mentioned by Hembrow.[13]

In general, left-sided appendices will be found to fall under one of the following four categories:

(1) Complete or incomplete visceral transposition.

(2) Nonrotation of the colon.

(3) Imperfect fixation of the cecum and ascending colon.

(4) Excessively long appendix with the tip to the left of the midsagittal line.

In addition there may be such rarities as that encountered by Kirklin and Hodgson,[14] in which the cecum and appendix were found in the left thoracic cavity due to a congenital defect in the left diaphragmatic leaf.

Because the visceral afferent nerves are not affected by an incomplete rotation or migration of the cecum, uncomplicated appendicitis in such cases should give pain referred to the right lower abdominal quadrant.[13] That such is often true we know from instances where at operation second or left-sided incisions have had to be made. The same

should be true in imperfect cecal fixation or excessive length of the appendix, with the tip lying on the left side.

For like reason the pain should be referred to the left lower abdominal quadrant in appendicitis in cases of complete visceral transposition. Early in appendicitis the pain is referred to the epigastrium because the sensation is carried over the visceral afferent fibers. Later, as the parietal peritoneum becomes involved in the inflammatory process, the sensation of pain travels over the sensory portion of the appropriate spinal nerve (usually T-11, T-12, or L-1). Thus, in any instance of acute suppurative appendicitis where the parietal peritoneum is involved, the pain will be localized to the area of skin overlying the inflammatory process regardless of the position of the appendix. In other words, in a case of acute appendicitis on the left side with parietal involvement one should expect the pain to be on the left side.

Diagnosis of left-sided appendicitis should not be difficult if one keeps in mind the possibility of visceral transposition whenever pain is encountered in the left side of the abdomen. However, one must differentiate this disease from acute diverticulitis of the sigmoid colon, intrauterine pregnancy, left tubal pregnancy, left ovarian cyst twisted on its pedicle (or bleeding from a hemorrhagic corpus luteum cyst), acute salpingitis, incarcerated or strangulated left inguinal or femoral hernia, torsion of the omentum, volvulus, fecal impaction and intussusception. In all respects the clinical course, physical findings and laboratory findings of appendicitis in situs transversus viscerum are identical with the same condition on the right, except for the mirror-image reversal of the patient's viscera.

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AN UNUSUAL PHYSICAL FINDING IN A CASE OF LEFT VENTRICULAR ANEURYSM

JOHN F. LING, M.D.*

RICHMOND

A. DAVID MCKINLEY, M.D.**

INDIANAPOLIS

A DEFINITE pulsating mass in the upper abdomen is rarely associated with cardiac aneurysm. The following case illustrates this unusual physical finding.

C. W. V., age 62, white male, was first admitted to the Medical Center July 3, 1945. His admission complaints were: 1. pressure in the chest. 2. shortness of breath. 3. a productive cough. 4. constipation.

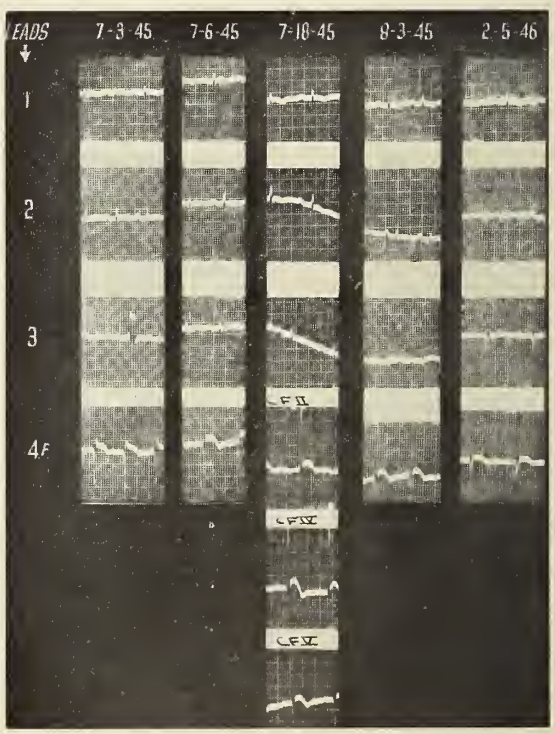
Five weeks prior to admission, while hoeing in a garden, the patient was suddenly seized with a feeling of constriction, with no pain, across the heart. He sweated profusely, felt cold, and had a diarrhea lasting two to three days. He also had dyspnea and orthopnea and a productive cough. He improved over a three week period and returned to work the day before admission. In the evening of the day prior to admission, the patient had an episode similar to the first one. The patient had considered his health good prior to these episodes.

On admission the patient did not appear acutely ill. He had dyspnea and orthopnea. There were moist rales in both lung bases, the liver was palpable 5 cm. below the costal margin in the right mid-clavicular line, and there was a slight pretibial pitting edema. The precordium was not overactive, the apex was 3 cm. lateral to the mid-clavicular line in the 6th intercostal space, and no thrill was felt. A friction rub, systolic in time, was heard beneath the apex obliterating the first sound and was transmitted to the lower left chest posteriorly. A systolic murmur was heard just medial to the apex. The first heart sounds were absent at the base. The rate was 100 with a regular rhythm. Blood pressure was 140/100.

The serology was negative. Urinalysis on admission was reported as showing a faint trace of albumin, three to four finely granular casts, and a normal specific gravity. Forty-one percent of the P.S.P. dye was excreted in 15 minutes. Hemogram was as follows: hemoglobin 10 grams; W.B.C. 11,000; moderate shift to the left in the differential count. Sedimentation rates were 25 and 30. X-ray of the chest revealed marked enlargement of the cardiac shadow with accentuation of the left ventricular portion and a "boot shaped" configuration. There was evidence of congestion in both lung fields. (See fig. 2A.) Electrocardiogram showed low voltage of the QRS in the limb leads with absent R in 4F, and inversion of T_1 and T_4. Serial tracings showed inversion of T_2 becoming upright again fifteen days after admission. There were no further changes to death. (See Fig. 1.)

The patient was afebrile during his hospital stay. The patient's congestive failure was treated

Figure 1.



Electrocardiographic tracings taken on the dates indicated.

From the Departments of medicine and Cardiology, Indiana University Medical Center, Indianapolis.

* Formerly Resident in Medicine.

** Assistant in Medicine, Indiana University Medical Center.

with salt restriction and digitalis. The first injection of a mercurial diuretic given intramuscularly produced good results; however, a few days later, fifteen minutes after intravenous injection of the same mercurial diuretic, the patient abruptly developed severe dyspnea, profuse sweating, and a very rapid irregular pulse. Within two hours the patient had apparently recovered from this episode. Note was made of the fact that he had been observed to have what was thought to be paroxysmal auricular fibrillation nine days previously. The patient continued to recover from congestive failure and was released on bed rest nineteen days after admission.

Two weeks after release the patient decided to get out of bed. He suffered another attack of chest discomfort. He presented himself at the hospital the following day, August 3, 1945, and was readmitted. The findings at that time were those of minimal cardiac decompensation; blood pressure was 110/75. The electrocardiogram was unchanged except that T_2 was then upright. The patient improved and was released August 10, 1945, seven days after admission, with instructions to continue complete bed rest for three weeks.

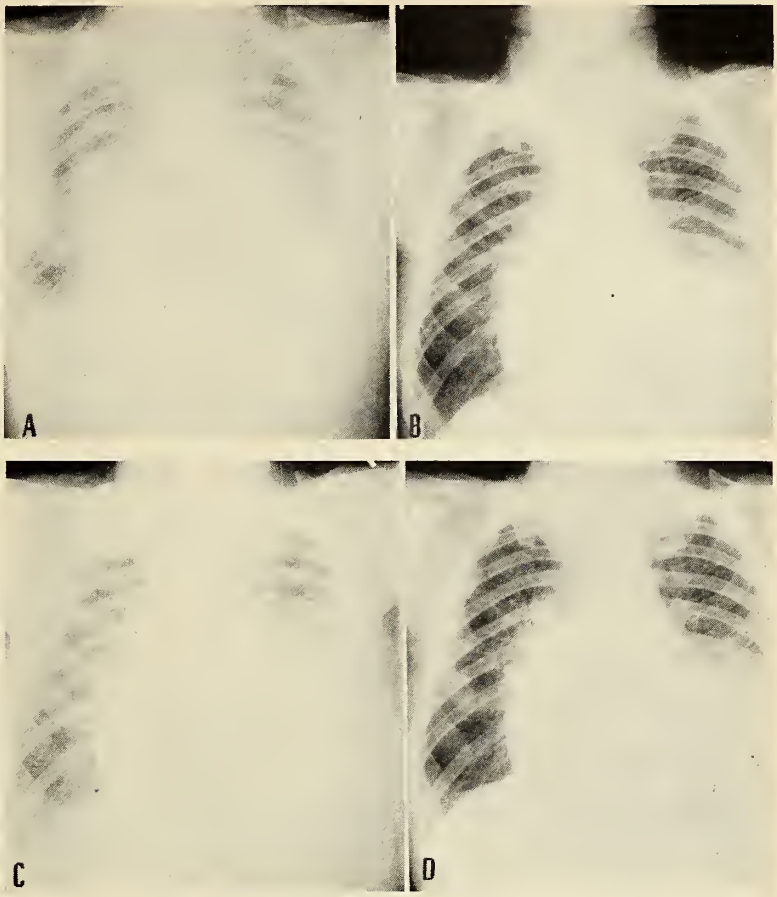
The patient was followed in Outpatient Clinic and remained in mild decompensation in spite of treatment. The state of decompensation became worse and he required readmission on November 22, 1945. The findings on that admission were those of rather marked cardiac decompensation. The heart findings had not changed from the previous admission except that a diastolic gallop rhythm was present. Blood pressure was 140/110. A chest plate revealed a homogenous density obliterating the lower third of the left pleural cavity. This was interpreted as a collection of pleural effusion. The heart and mediastinum appeared to be pushed to the right. There was no evidence of congestion in the lung fields. (See fig. 2B.) The patient responded to treatment, including intramuscular injections of a mercurial diuretic and was released twenty days after admission, on December 11, 1945.

The patient was followed in the Outpatient Clinic and again admitted February 4, 1946, with symptoms and findings of congestive heart failure. A pleural effusion was found in the left chest and 1,000 cc. of amber, slightly cloudy fluid was aspirated. The fluid was sterile on culture and had specific gravity 1.012. He received one mercurial injection intramuscularly. X-ray findings following removal of the effusion fluid showed the left costophrenic angle to be obscured by some density over the lower left chest. (See fig. 2C, before aspiration, and 2D, after aspiration.) The heart shadow and trachea were still shifted to the right. Heart measured transventricularly 20 cm. compared to a transthoracic diameter of 31 cm. The heart had a typical boot-shaped configuration. Electrocardiogram showed no change. The patient was discharged eleven days after admission. Blood pressure was 140/100.

The patient was seen three times in the Outpatient Clinic. He developed an increasingly severe cough, productive of white mucoid sputum. He remained compensated. On the last clinic visit he complained of a diarrhea starting that day.

The patient's last admission was May 3, 1946,

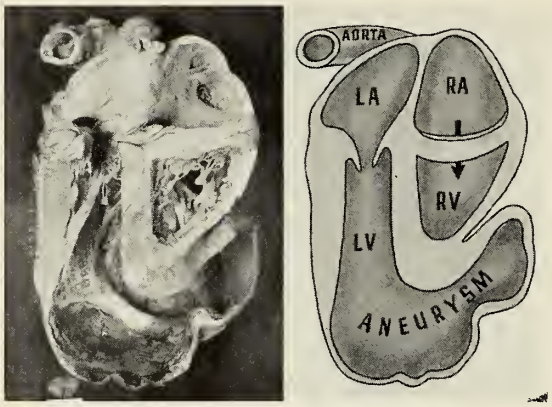
Figure 2.



X-ray studies of the chest taken P.A. at 6 feet.

A—July 3, 1945—first admission.
B—November 30, 1945—third admission.
C—February 11, 1946—fourth admission, before aspiration of fluid.
D—February 14, 1946—following aspiration of 1,000 cc. of fluid.

Figure 3.



The photograph and accompanying drawing show the posterior surface of the heart which lay in transverse position in the chest.

with complaints of eight to ten liquid stools daily and vomiting immediately after ingestion of food or water. The stools were observed to be of "rice water" character. No gross blood was seen in either the stools or vomitus. The patient was acutely ill but had no fever, and was not in congestive failure. The left border of cardiac dullness was in the anterior axiliary line. The rate was 80 with a regular rhythm. There was a soft blowing systolic murmur at the apex. Blood pressure was 132/84. There were no rales in the lung fields.

In the upper left quadrant of the abdomen there was a very surprising finding. There were two masses, each about 4 to 5 cm. in diameter. The lateral mass was firm but the medial one was pulsatile. These pulsations were thought to be expansile and were synchronous with cardiac systole. The presence of this pulsating mass was confirmed by several observers. None of them had encountered such a mass in their previous experience. Both of these masses seemed to project from under the costal margin.

The diarrhea and vomiting subsided after two days. On the third day the patient was observed to be in shock, which lasted four to five hours. He was treated with oxygen and plasma. Following this episode the patient remained semicomatose, and his course was progressively downhill. Six days after admission "uremic frost" was observed over the forehead and face. In spite of adequate intravenous fluids, the patient developed oliguria. He lapsed into coma, developed Cheyne-Stokes respiration, and a slight pitting edema of the lower extremities. An erythematous macular rash appeared on the eighth hospital day, spreading to cover the entire body except the palms and the soles of the feet. The patient died on the tenth hospital day.

Laboratory findings: Blood counts were normal except for slight Schilling left shift; urinalysis showed a trace of albumin. Stool examination showed mucus, pus, a trace of blood, and the presence of Trichomonas hominis on culture. TNPN rose from 113 on admission to 225 at death; creatinine rose from 5.4 to 7.5. CO_2 combining power terminally was 39 volumes percent.

X-ray: Barium enema was normal. Fluoroscopy and scout films of the abdomen revealed no definite mass. There was no erosion of bony structures. The apex of the heart was in the left axillary line.

Necropsy findings: The findings will be limited to those found in the heart. The heart was seen to be grossly enlarged and showed loss of normal outline. It lay in what appeared to be a transverse position in the chest. Upon opening the pericardial sac, there was encountered approximately 45 cc. of a bloody fluid within the pericardial sac. There was a sacular outpouching of the myocardium on what appeared to be the anterior surface of the left ventricle.

The heart weighed 700 grams. The pericardium was closely adherent to the epicardium over the above-mentioned outpouching of the myocardium. The origin of the vessels from the heart was normal. Dissection of the coronaries showed a severe atheromatosis with 60 percent to 75 percent of all branches narrowed by calcified plaques. In addition, at a distance of 3.5 cm. from its origin, the left descending coronary was grossly completely occluded. This was at the margin of the myocardial aneurysm. Upon opening the left side of the heart, the left auricle and mitral valve were seen to be normal. There was a large aneurysm (4 x 4 cm.) which arose from the myocardium of the left ventricle near the apex (see fig. 3), and an even larger one (6 x 4 cm.) which involved the lower portion of the intraventricular septum.

These aneurysms contained mural thrombi (combined weight 650 gm.). The large aneurysm of the intraventricular septum bulged anteriorly and infringed upon and reduced the size of the chamber of the right ventricle. The smaller aneurysm at the apex of the left ventricle was covered by a thin shell of myocardium which was paper thin.

The gross appearance of the right auricle, right auriculoventricular valve and right ventricle was normal, except for the reduction of the size of the chamber of the right ventricle because of the size of the intraventricular aneurysm.

Histological study of the myocardium showed scattered strands of collagenous fibers radiating through its substance. There was an abrupt transition of this fibrosed myocardium to the wall of the aneurysm. The wall of the aneurysm was approximately 20 percent as thick as the myocardium. It was composed of strands of fibrous tissue and degenerating myocardial fibers. There was considerable necrotic debris within this thin mem-

brane and this debris consisted of degenerating muscle nuclei and degenerating mobilized phagocytes. On the endocardium of the aneurysm wall there was an organizing thrombus. The thrombus was composed of a mass of fibrin containing no recognizable blood cell remnants.

Histological sections of the anterior descending branch of the left coronary taken at two levels showed a marked atherosclerosis of this vessel with calcification. The lumen of the vessel was narrowed to approximately 10 percent of normal; this had been thought to be completely occluded on gross examination.

The final anatomical diagnoses were:

(1) Arteriosclerotic heart disease.

(2) Aneurysm of left ventricle due to infarction.

(3) Bronchopneumonia.

DISCUSSION

Cardiac aneurysm was first clearly defined by Baillie[1] in 1793, as follows: "It sometimes happens, although I believe very rarely, that the heart becomes aneurysmal. This disease consists in a part of it being dilated into a pouch, which is commonly more or less filled with blood." Crawford[2] defined cardiac aneurysm as a bulging beyond the contour of the rest of the heart, this being in contradistinction to a mere thinning of the heart wall. This case is one of true aneurysm.

The incidence of cardiac aneurysm has been reported as occurring in from 9 percent to 38 percent of cases of myocardial infarction.[1, 3, 4, 5] It is interesting to note that Libman[5] stated that aneurysm of the left ventricle occurs 15 times more often than Hodgkin's disease. Like myocardial infarction, cardiac aneurysm is much more common in the male.[1, 2, 6]

The etiological causes of cardiac aneurysm have been listed as arteriosclerosis with myocardial infarction,[1,2,3] luetic, due to focal gummatous myocarditis,[7] mycotic secondary to bacterial endocarditis,[8] rheumatic, due to rheumatic necrosis of the myocardium,[1] tuberculous,[9] congenital, either of the pars membranacea septi or cardiac diverticula,[1] and traumatic.[1] The most common cause by far is coronary sclerosis with myocardial infarction,[1,3] accounting for 85 percent of cardiac aneurysms.

The site of cardiac aneurysms in order of frequency is: anterior apical wall, lateral wall, posterior wall of the left ventricle. This case falls into the most common group. Following myocardial infarction there is healing by replacement fibrosis with thinning and subsequent stretching due to intraventricular pressure. The size is dependent upon the area of the original infarction, the formation of mural thrombi, the formation of pleural-pericardial adhesions, and thickening of the epicardium.[1,2,3]

The most common clinical diagnostic features of cardiac aneurysm are as follows: 1. Previous history of myocardial infarction and congestive heart failure. 2. Cardiac enlargement, with weak first apical heart sound, and a diffuse heaving precordial impulse. 3. An expansile pulsation separate from the true apex and below the level of the third rib.[10] Only once previously has an abnormal pulsation been reported in the abdomen;[2] we wish to reemphasize the importance of this finding.

The Electrocardiogram: From the literature, the commonest type of electrocardiogram is one showing the residual features of an old anterior or anterolateral wall infarction, together with a marked right axis deviation (preponderance).[4, 11] It consists of a low R_1, deep S_1 and S_2, inverted T_1 with upright T_2 and T_3, often a Q_1, often an absent R_4 with elevated S-T segment passing directly into an upright T_4; the S-T segments of all three limb leads may be elevated and there may be low voltage of the QRS complexes in the limb leads. Such a tracing is seen in 36.4 percent of cases of cardiac aneurysm. The marked right axis is seen in spite of a corresponding increase in left heart size, and, though the pattern is seen in healing infarction, its persistence beyond the healing stage is very suggestive of cardiac aneurysm.

The second most common type of tracing consists of a right axis deviation with evidence of an old anterior or anterolateral wall infarction. It shows a deep S_1 and possibly S_2, upright P_1, inverted T_1 with elevated S-T segment, and depression of S-T_3. There is a downward deflection of QRS_4 (V_4). This is seen in 27.3 percent of cases.

In 18 percent of cases bundle branch block is found.

In a similar percentage the electrocardiogram was less specific, but still had changes which might suggest aneurysm by showing marked left axis deviation without corresponding left ventricular enlargement, by showing a right axis deviation which is rare in hypertensive or arteriosclerotic heart disease,[11] or by showing a pattern associated with "recent or healing" myocardial infarction which persists far beyond the recovery period. Our case falls into this last category. (CF Fig. 1).

In spite of clinical or electrocardiographic studies, the final diagnosis must rest in the roentgenological findings.[1,3,6] These findings are:

1. Enlargement of the left ventricle with deformity of its contour.
2. An abnormal protuberance, proved fluoroscopically to be part of the heart shadow.
3. Paradoxical, abnormal, or absent pulsation of the protuberance.
4. Evidence of adhesions between the heart and the chest wall or diaphragm.

5. A very helpful finding, when present, is calcification of the aneurysmal wall or mural thrombus.

The outlook in cardiac aneurysm is poor, however one should not take too pessimistic a view as to prognosis, for some patients have been known to live for a number of years.[12]

SUMMARY

1. An unusual case of left ventricular aneurysm and intraventricular aneurysm following myocardial infarction has been presented.
2. The importance of abnormally located pulsations near the heart, both above and below the diaphragm, has been stressed. In this case the abnormal pulsation was found in the left upper quadrant of the abdomen.
3. The post-mortem findings are described.

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MULTIPHASIC SCREENING

THE popularity of screening programs for the detection of single chronic diseases has increased during recent years. The interest on the part of the public in these mass surveys, and participation in them on a fairly wide scale, has advanced the idea that screening technics might be carried out for several diseases at the same time.

Instead of gathering people together for miniature chest x-rays at one time, and conducting tests for the detection of diabetes at another, and then running a series of blood pressure determinations or serological tests for syphilis at still another time, it has been suggested that a group of tests be obtained, all at the same visit, and at a considerable saving so far as administrative costs and time are concerned.

This proposal is not new, and in fact has been utilized in several centers in the United States. The Herman G. Morgan Health Center in Indianapolis has performed multiple screening tests for its beneficiaries and in particular for food-handlers for several years. The medical society and health departments in San Jose, California, recently conducted such a survey among the employees of four establishments.

The disposition of patients with positive findings is handled in the same way as are those in a single disease survey, with a notice indicating the nature of the finding and advice for consultation with the family doctor.

Naturally only a few of the diseases to which human flesh is heir may be detected by such a procedure. The value of the effort is that it will detect quite a few chronic diseases, which are common enough to be of public health importance, and which pass through a phase which is nonsymptomatic or almost so, during which phase treatment is more effective than it would be in a later and more symptomatic stage.

The conditions usually chosen for screening are those in which tests may be conducted by technicians with some professional supervision, and with the interpretation of the findings to be done later by a physician.

Actual tests conducted on a group of presumably healthy workers have shown that between two and two and one-half percent of those tested will be found to have clinically significant and previously unrecognized disease. In addition, several times this number have been discovered to have

abnormalities which were slight, but which could profitably be corrected.

One disadvantage of the multiple screening clinic is that it may, unless careful steps are taken to prevent it, give its patients a false sense of security. In the case of those individuals with normal findings, it is possible to surmise that some may have any one of a host of other diseases, possibly with symptoms, and neglect to have an adequate diagnostic study by their physician, solely because the screening clinic has given them (at least in their own minds) a clean bill of health. In fact, experience with laboratory tests teaches us that negative findings do not give a 100 percent assurance as to the absence of the specific conditions tested for.

Editorial comment in the July 1950 number of the *North Carolina Medical Journal* points out that such procedures cannot make diagnoses, and that a carefully taken history is the most important single factor in diagnosis.

In so far as multiphasic screening detects incipient nonsymptomatic chronic disease and succeeds in influencing the patients to seek professional care, it will be successful.

People who undergo screening technics should never be allowed to think of the procedure as a "periodic health inventory," a "complete physical check-up," or as a diagnostic study to determine the cause of symptoms.

Multiphasic screening cannot at the present time be applied to the detection of malignancy. Everyone who passes through such a clinic should understand that the tests are intended as a mass screening for a few specific conditions, and that if they are symptomatic in any way or desire a complete examination, their physician is the one to see.

PENSION PLANS

THE American people as a whole and physicians as well have never been as pension- and security-conscious as they are today. This is seen in the wave of strikes in industry to obtain pension and disability or health insurance, or to better the terms of such if they were already in effect. The constantly recurring efforts to extend the coverage and benefits of the Social Security Act is another case in point.

A committee of the Council was appointed to look into pension plans for the members of the Indiana State Medical Association. In the work of this committee in attempting to formulate or evaluate such plans several facts soon became apparent.

One such fact is that interest rates are no longer what they were. The days of 5 or 6 percent return on money put into pension plans and annuities are gone, and there is no present sign of their return.

Another difficulty is in pliability and adaptability of such pension plans. The needs of doctors of different age groups may vary considerably. We have endeavored to meet this by asking the various companies presenting plans to make them pliable enough to cover such varying requirements and needs.

Physicians in general have rejected the idea or suggestion of broadening the Social Security Act to cover professional men. We much prefer to provide our own protection. But how? That is the question. Different doctors answer this in different ways, which is as it should be.

But, we all know physicians who have made plenty of money in the days of their greatest productivity who, because of unwise investments or lack of foresight, approach their declining years with the prospect of insufficient income.

An organized pension plan is one way to protect oneself from this contingency and carries with it certain tax advantages not possessed by other investment plans. It is hoped that soon a comprehensive plan or plans now under way will be formulated for presentation to our state society members.

E. R. Clarke, M.D., Chairman,
Special Committee on Retirement Income Plan.

A BIG STEP FORWARD

HOW WELL could even a "high powered" executive run a large and far-flung business, how much cooperation from his staff could he hope for if he were out of touch for long periods of time with many members of his organization? The answer is, of course, to shrug the shoulders. Yet that is exactly the way in which the A.M.A. has operated for years, and we indeed approve the recent action whereby a subscription to *The Journal of the American Medical Association* is included with each paid membership in that organization. *The Journal* is the mouthpiece of the Association, and also the coordinator and advisor for the scattered membership, and thus is doubly important to organized medicine in this country. The fact that this policy follows that of many state associations (including Indiana) and gives each member something tangible for his dues is also appealing, but the big point is that *The Journal of the American Medical Association* will be placed in the hands of more doctors than ever before. This should automatically put each member on a par with all the others, create interest where it has been lacking, and lead to a more progressive, as well as a stronger, A.M.A.

GET OUT THE VOTE

IN addition to the right and duty of each individual doctor to further the candidacy of those whom he favors for public office, each of us has the solemn duty of voting, and of encouraging all other citizens to vote. Medical societies as such may not participate in campaign activities, but may engage in activities designed to increase the use of the ballot.

"Medical societies not only have a right, but an obligation, to participate in registration drives and 'Get Out the Vote' campaigns, where the purpose is to encourage people to exercise their right of franchise, rather than to support any given candidate."

The medical profession, in its efforts against national compulsory health insurance, has enrolled the support of well over 10,000 national, state and local organizations. Total membership in these groups amounts to many millions. It is imperative that these citizens and all other advocates of freedom of medicine express their opinion on the issue of government controlled medicine which has been injected into the present campaign.

The privilege and obligation of voting is one of the most fundamental principles of American democracy. All those who fulfill this obligation and who encourage others to do likewise are contributing to the strength of those processes which have made this country great.

RETIREMENT

THE prominence recently accorded to retirement and pension plans in labor union negotiations with industry, accompanied for the most part by simultaneous demands for wage increases, brings us inevitably to a thoughtful consideration of the effect of these things upon the medical profession. For the most part, physicians as self-employers must provide for their own needs out of earnings; it is part of the price of independence.

However, provision for old age and retirement necessarily has to be made over a long period of time. During this time interval what happens to the national economy is of the greatest importance. Anyone who has tried to fill a bathtub with the drain improperly stopped is in a position to know the result, but few apparently apply the knowledge thus gained to a consideration of their future under a nationally unbalanced budget.

Deficit spending is an insidious evil, because it causes a slow and relatively unnoticed shrinkage in dollar value. When government borrows to meet current bills, its most convenient source of cash is commercial banks. The fact that they do not have the money on hand is no trouble at all. The banks merely ask Uncle Sam for some IOU's called bonds, and in return they give him a checking account equal to the figures printed on the bonds. Then Uncle Sam writes checks to pay his bills, and everybody is happy. More dollars are put in circulation, but the supply of goods that can be bought remains the same. So, every dollar in the nation loses value. "Dollars of your savings account, your salary, pension, life insurance, and bonds slowly shrivel. During World War II, such wildcat financing shrunk your dollars in half."[1]

A little thought ahead will certainly raise the question in every doctor's mind: What will my accumulated dollars be worth when it comes time for me to retire, if this shrinkage continues?

Already it has become necessary to increase social security benefits and welfare allowances to keep pace with rising costs and shrinking dollar values, and no attempt has yet been made to reduce the enormous public debt. Medical schools and hospitals are facing huge deficits unless they accept subsidy. Powerful labor union pressure is continuing for increased wages, shorter hours, pensions, welfare schemes, in spite of dwindling foreign markets for paid-for, not give-away goods. What price your savings? How long can we spend more than we make without disaster?

If you plan at some time to retire or even to continue working, give these things some thought. Coming elections afford the opportunity for every citizen-taxpayer to make his views known. Will you condone deficit spending and mounting debt by your silence?

—*New York State Journal of Medicine*

[1] Release No. 117, Committee for Constitutional Government, April, 1950.

More than one hundred years ago Thomas Jefferson said:

"I place economy among the first and most important virtues, and public debt as the greatest of dangers to be feared. To preserve our independence, we must not let our rulers lead us with perpetual debt. We must make our choice between economy and liberty, or profusion and servitude. If we run into such debts, we must be taxed in our meat and drink, in our necessities and in our comforts, in our labors and in our amusements. If we can prevent the government from wasting the labors of the people under the pretense of caring for them, they will be happy."

President's Page

BATTLES AND BOUQUETS

THE Korean conflict is becoming a bigger crisis every day, and we seem to be drifting into another war. The nation expects men in the armed forces to have adequate medical care, and they expect this care to be supplied by men who were deferred during World War II in order to pursue their medical education. The medical profession has always met every emergency voluntarily, and I have confidence that the doctors of Indiana will do their part to continue the profession's fine record.

Some of you have not yet paid your AMA membership dues. I urge you to do this immediately, or we will lose a delegate. Surely $25 is little enough to pay for liberty and the maintenance of your freedom in the practice of medicine. Now, in the face of active warfare, is no time to let down and permit compulsory medical insurance to creep into our national economy.

We physicians are not fighting socialized medicine by ourselves. Pharmacists, dentists, and veterinarians, realizing that their own professions would quickly follow ours down the road to servitude under government supervision, are working just as hard as we are to prevent the hazard of socialization. We are grateful for their work against this common threat. Then, too, our staunch supporters—the Auxiliary members—are untiring in their efforts to counteract any socialistic trends that would be harmful to the public as well as the medical profession.

I want to thank all committee members for their activity this year in the various fields to which they were appointed. We are all obligated to these faithful physicians who have worked so diligently for the betterment of the medical profession. The Executive Committee and the Council have had regular meetings; both have served wisely and well.

A wonderful staff in the headquarters office has done a remarkable job of keeping every Indiana doctor posted on the activities of the society. This staff is largely responsible for the smooth operation of the Indiana State Medical Association, and I want to commend them especially, for they have been of tremendous help to me.

You bestowed a great honor upon me when you elected me your president for 1950, and I appreciate the loyal and enthusiastic support each of you has given to the program of the association. I have greatly enjoyed working with President-elect Ellison, and now—the next by-line is yours, "Judge."

Medical Panorama by the Associate Editor

Will History Repeat?

Members of the generation who can remember how things were before World War I, and what the general attitude of the average citizen was at that time, must often pause for thought when confronted by the superficialities of 1950. Even the psychiatrists do this, and below is a quote very much to the point in good, clear, unpsychiatric English.

While we should use every means at our command to seek and destroy Communism in our midst, the only impenetrable defense against Communism is American character. Our colonial forefathers were not afraid of what one Indian, or a dozen, living in their settlement might do to their culture; our forefathers were strong characters. If American character today is strong and self-reliant and knows what its objectives are, the Communist, if he remains in our midst, will remain impotent. But if we are jellybeans—a bright, sweet, shiny crust with only jelly inside—the stronger character may injure us regardless of numbers.

History tells us that the civilization which indulged in the flesh-pots, pleasure, ease, and irresponsible life was easy prey for other nations who were tough, hard, and had met privation, who had little to lose and everything to gain. It takes a much stronger character to stand prosperity than adversity (provided, of course, that the individual actually survives the adversity). We should take a good look at ourselves and ask ourselves whether or not the individual American is being made stronger, more self-reliant and better able to withstand the "slings and arrows of outrageous fortune."

The best possible answer for us, as a nation which has become "punch drunk" in the battle for men's minds, is to see with increasing clarity what our American ideals are, why we are living, and to reach beyond the gadgeteering of the day. Then and only then will we be able to build up a defense against the battle for our individual and collective minds. The "American way of life" should come to mean something besides a catch phrase.

From Annual Review of Psychiatry
By C. C. Burlingame.

If we had more "character" perhaps we would make less demand for "social security."

Repititio Mater Studiorum Est

We wish we could reprint the entire address of the president of the California Medical Association, Dr. R. Stanley Kneeshaw, delivered at their 79th annual session, entitled "Case History of Uncle Sam," and published in *California Medicine*. He says again what has been said before but he puts it cogently, partly in case history medical style, partly straight forward. While this Journal has hammered on this particular anvil many times before, a few more taps won't do any harm. Repetition is the mother of learning.

Speaking of medical care plans, Doctor Kneeshaw has some sage advice regarding the need to avoid being stampeded in the matter by the tremendous pressure being applied from all sides:

As yet, no plan has been evolved that can include everyone. There are some people who will budget everything but the cost of sickness. Some cannot yet afford it. Others will not protect themselves if they can afford it. But, because no all-inclusive plan has been developed since such plans have been inaugurated is no reason why the government should take over and spoil all the plans that have been effected. Oscar Ewing admitted that if the government health plan were enacted, the Blue Cross and other plans would be forced out of business as a result.

Private enterprise has to keep these plans on a sound financial basis; it cannot compete with a ready-spending government bureau. Many hastily promoted pension plans and health plans will sink under their own weight, or some of the services will have to be curtailed. Let us not be in too great haste to adopt some of the numerous plans that are being offered by some of our legislators. A certain hysteria has developed in Washington because of the impending threat of the bureaucratic schemes, but let us not be stampeded into accepting some plan which will finally result in the American public's getting poorer medical care.

I appeal to the medical profession to stand firm on the gradual, careful planning by the parties that are interested in giving protection to the people. There should be conferences of the Blue Cross-Blue Shield groups, of the insurance groups and of the financial experts to the end that more people will finally be included in the plans, with perhaps longer coverage, and perhaps some deductible plan in which the patient would share in the initial expense. All these variations are being tried, but so much pressure is being applied to them that the groups are becoming panicky and unable to think clearly. We should not permit destruction of what has been accomplished in these last 20 years.

What, then, should we do?

We should alert ourselves to the fact that we have other responsibilities than that of caring for the sick. We should accept our duties as citizens as well. We should interest ourselves in civic affairs and pay more attention to some of the jobs we have delegated to others. We should be *voters*.

Yes, let us give Uncle Sam an injection of some of the Spirit of 1776, to the end that his drooping shoulders will be straightened, his head will be again held high, his back straight and once again with Liberty on his arm, he will march forward.

See what we mean? Don't neglect your part in injecting votes into Uncle Sam.

THE FOUR DOCTORS, FORTY-FIVE YEARS AFTER*

W. D. Gatch, M.D.

INDIANAPOLIS

"The Four Doctors" by John Singer Sargent
Welch, Halsted, Osler, Kelly

THE founding of the Johns Hopkins Hospital and Medical School is perhaps the most interesting episode in our medical history. The men who took part in it had a predominant and lasting influence on medical education and practice in the United States. These facts encouraged me to hope that you would be interested in this subject.

John Singer Sargent in 1905 made a group painting of Welch, Osler, Halsted and Kelly, the four great men of Hopkins. They were then at the very top of their professional careers. This is one of the most celebrated of modern paintings. It may in times to come do more to immortalize these doctors than all their mighty works in medicine. I have come to think that it marks the end of one era in American medicine and the beginning of another.

Johns Hopkins, a wealthy citizen of Baltimore, gave in 1873 nearly all his fortune of several million dollars for the construction and endowment of a university, a great hospital, and a medical school. The success of these institutions was in great part due to the first president of the Johns Hopkins University, Dr. Daniel Coit Gilman, (1831-1908) who took office in 1875. His ability to select talented men was remarkable. The people of Baltimore thought he would erect fine buildings, but he immediately announced a policy of brains instead of bricks. He housed the university in old buildings and invested the Hopkins millions in the most gifted faculty ever collected in the United States.

President Gilman first established the University. It immediately became the chief—in fact for a long time about the only—institution for research and postgraduate instruction in the country. When he got around to planning the hospital and medical school he sought the advice of Dr. John S. Billings (1839-1913). Now Doctor Billings deserves to be rated among our greatest physicans. He was born in the hills of Switzerland County, Indiana, at Allensville. Dr. Clyde Culbertson, who recently visited this place, informs me that it is now a ghost town and that none of the people thereabout to whom he talked had ever heard of the Billings family. Doctor Billings was graduated from Miami University at Oxford, Ohio, and, just before the Civil War, from a medical school in Cincinnati. He was very poor. His education seems

* Address as retiring President of the Indianapolis Medical Society, delivered January 24, 1950.

to have been largely acquired by himself and was not due to any great advantages for study or to special scholarly surroundings.

He joined the Medical Corps of the Union Army when 24 years of age, at the beginning of the Civil War. He served with distinction on the battlefield and in army hospitals throughout the war. He is said to have been the first surgeon ever to resect the ankle joint with survival of the patient. After the war he was stationed in Washington on the staff of the Surgeon General. Doctor Welch said this about him: "The central work of Doctor Billings was of course the library of the surgeon-general's office, and the museum, enduring for all time. I question whether America has made any larger contribution to medicine than that made by Doctor Billings in building up and developing the surgeon-general's library and in the publication of the Index Catalogue and Index Medicus. That in my judgment is our greatest contribution to medicine, and we owe it to this extraordinary man. . . . His was our most famous name, as far as European reputation is concerned, with the possible exception of Dr. Weir Mitchell, during the decades between 1870-1890. . . . Of all the men I have ever known he was about the wisest."

Doctor Billings was the foremost authority in the United States on public health and sanitation. While librarian to New York City toward the end of his life, he united three separate libraries and built the present library building. When still army librarian he designed the Johns Hopkins Hospital and with President Gilman formed the ideals and general policies of the medical school.

The hospital was opened in 1889; the medical school in 1893. According to MacCallum, Billings selected Welch for professor of pathology; Welch won Billings over to the choice of both Osler and Halsted; Kelly was entirely Doctor Osler's choice. This is how the four doctors got started in Baltimore. Other men at Hopkins—Abel in pharmacology, Howell in physiology, Mall in anatomy and many others—equaled or surpassed them in scientific achievement, but no American physicians, the Mayo Brothers excepted, have equaled them in fame or in influence on American Medicine. Welch, Osler, and Halstead had studied in Germany. Kelly was a self-educated genius.

Up to World War I Germany led the world in medical science. Virchow had developed cellular pathology, His embryology, Cohnheim experimental pathology, Koch bacteriology. Dozens of men of lesser note had made valuable discoveries. Germany also surpassed all other countries in the optical industries and in chemistry. In sad contrast medical science in the United States hardly existed. The College of Physicians and Surgeons in New York had no microscopes when Welch was a medical student! The Hopkins school, staffed as it was by men trained in Germany, had many characteristics of a German school of that time. The students were supposed to be self-directive. They were not compelled to attend classes. The faculty did not bother about the extramural conduct of the student unless he got into trouble with the police. There were no deans of men or deans of women. There were no social events and no athletic activities. The total administrative force of the school consisted of a dean and one secretary.

One accustomed to a college having elaborate administrative, advertising, and social machinery might well think that the total lack of any effort to regulate student life or activities would have led to utter confusion and lack of college spirit. Quite the contrary. The students with few exceptions worked even too hard. Absence from classes was almost unknown. As for college spirit, it was too strong in many students for their own good. The lesson from all this is that to give a good education requires four things only: the selection of students who really want to be educated, the avoidance of spoon-feeding instruction, good teaching, and rigid examinations.

Welch (1850-1934) had the greatest influence on the development of the school and on everything relating to medicine here and abroad. He was born at Norfolk, Connecticut; graduated with honors by Yale, where it seems he could have become Professor of Greek; received the M.D. degree from the College of Physicians and Surgeons in New York; studied pathology and bacteriology in Germany, where he was most influenced by the teaching of Cohnheim in pathology and of Koch in bacteriology; established a laboratory of pathology in New York; came to Baltimore in 1884 as Professor of Pathology. He built a powerful Department of Pathology in the Hopkins Medical School. He directed the research which led to the discovery that yellow fever is transmitted to man by mosquitoes. He founded the Rockefeller Institute for Medical Research, the Pekin Union Medical School, the School of Public Health and the Department of Medical History at Johns Hopkins.

H. L. Mencken has given us this lively description of Doctor Welch's habits: "The late Dr. William H. Welch, one of the stars of the Johns Hopkins Medical School, was a sort of walking reductio ad absurdum of some of the most confident theories of his fellow resurrection men. For diet he cared precisely nothing, yet he lived to be 84. In exercise he took so little interest that he never had a golf-stick or even a billiard cue in his hands, yet he was hale and hearty until his last brief illness. And to top it all, he came into the world with the very sort of physique which, if the insurance statisticians are to be believed, means certain death before 50.

"Doctor Welch was hardly more than five feet six inches in height, but he must have weighed close to 200 pounds. With his broad brow, fine eyes and closely-clipped beard, he was a very distinguished looking man, yet it would have been difficult to prove legally that he had a neck. His massive head, in fact, sat directly on his sturdy

chest, and a foot below it there were the beginnings of a majestic paunch. This is the build, according to the professors of such matters, that offers ideal soil for a long list of incurable malaises. It spells high blood pressure, kidney deterioration and heart disease. When it is combined with a distaste for exercise, a habit of sitting up until all hours of the night and an enlightened appreciation of each and every variety of sound food and drink, it is tantamount, so we are told, to being sentenced to die in the electric-chair at 45. Yet Doctor Welch lived 14 years and 22 days beyond the canonical three-score and ten and had a grand time to the end. And when he died at last it was not of any of the diseases his colleagues had been warning him against for 60 years."

Osler (1849-1919) was a Canadian. After a sound classical education he took the M.D. degree at McGill University. He then studied pathology and clinical medicine in London, Leipzig and Vienna. He became professor of medicine at McGill, then at the University of Pennsylvania, and finally, in 1889, at Hopkins. He was the most illustrious physician of his day, and ranks among the greatest teachers of medicine. His great contribution to medical pedagogy in this country was the introduction of the clinical clerkship. Before Osler the American medical student seldom saw a patient. His manners were affable, his presence distinguished. His knowledge of medical history and of general literature was wide. He was an able speaker and writer. His popularity was almost unbounded. It made him, the story goes, accept the regius professorship of medicine at Oxford to get peace. This was in 1904. In his farewell address to Hopkins he ironically and with special reference to himself suggested that the world would be better off if all men were chloroformed at sixty. This remark, torn from its context, was immediately published in every paper in the country. A nation-wide denunciation of Osler followed. This was one of the two great misfortunes of his life. The other was the death of his only son which occurred in battle in Flanders. Osler's contributions to medical knowledge were few. His writings on nonmedical subjects are now almost forgotten. He owes his lasting fame chiefly to his textbook on the "Principles and Practice of Medicine," published in 1892. For 30 years this was used by almost every English speaking physician. "It set forth in clear and vivid language the entire body of medical knowledge at a time when this was still small enough to be generally comprehensible. It is the final statement on what can be accomplished in the way of diagnosis and prognosis by means of a good clinical history, a thorough physical examination, a knowledge of gross pathology, a knowledge of the natural course of disease, and the ability to reason; in other words without the help of laboratory study." It is still a valuable book.

Kelly (1858-1943) is today the least remembered of the four doctors but was probably the greatest genius of them all. This was Harvey Cushing's opinion. A partial list of Kelly's achievements supports it. He was first to catheterize the ureters as a routine procedure, first to establish medical art as a specialty, first, at least in this country, to use radium in the treatment of cancer, first to demonstrate stones in the kidney with the wax-tipped catheter. He was a most skillful surgeon. He and his pupils transformed gynecology. He was deeply religious, steadfast in his beliefs, courageous, resourceful, exceedingly kind and generous.

Halsted (1852-1922) had a most peculiar and baffling character. His parents were first cousins. He attended Andover and Yale. At Yale he went in for athletics and paid but little attention to his studies. He received his M.D. degree from the College of Physicians and Surgeons in New York and then went to Germany for further study. There he acquired an almost unbounded admiration for German surgeons and the German system of training surgeons. Back in New York he became a popular quiz master, obtained a number of good hospital appointments and did some private practice.

He and some associates began to experiment with cocaine for local anesthesia. They tried the drug on themselves and became addicted to it. Conquering this habit proved extraordinarily difficult. Halsted spent the year 1885 in a hospital in Providence, Rhode Island, and took a long sea voyage. Even after he came to Baltimore he had to go back to the hospital in Providence. The following is a quotation from Welch's introduction to MacCullum's "Life Of Halsted": "I had guarded unviolated for so many years the confidence which Halsted had placed in me that I confess I was surprised to learn that the secret of his habit was more widely known than I had suspected, and its publication after his death shocked me. I now realize that not only should the facts be made known, but that instead of reflecting injuriously upon Halsted's character, they bring out a strength of will and tenacity of purpose and a triumphant issue of a hard struggle rarely exemplified in similar circumstances." This habit and its conquest altered Halsted's character and changed his objectives and method of work. Before this experience he had been a tireless worker, operating and teaching constantly; after it he led a leisurely, thoughtful and much more productive life. He thus could thank his habit for his fame.

Halsted had very few intimate friends. The extreme formality of his manners made conversation with him difficult. His sarcasm was terrible. He dressed with the most fastidious care. He took long vacations. His eccentricities were many and remarkable. Surgery was almost his only interest. He was, however, not a born surgeon like Kelly. "Surgery," he said, "would be delightful, if you

didn't have to operate." He was the chief experimental surgeon in America. He was probably the first American surgeon to use the asceptic technique—this while he was in New York. He made the pioneer studies on wound healing—on the importance of hemostasis, of obliteration of dead spaces, of not devitalizing tissues by rough treatment, drying, or mass ligations. Time has shown that this was his most important work. He introduced the use of rubber gloves in surgical operations. He discovered nerve-block anesthesia. He enunciated the principle of block dissection for the treatment of cancer. He introduced into this country the resident system of training surgeons.

Halsted was intellectually honest. He would renounce his most cherished conclusions when the evidence showed them to be wrong, and many of them were wrong. He regarded himself as a pioneer worker. He became the founder of a cult. His present-day disciples would do well to follow the spirit rather than the letter of his teachings.

Such were the four eminent men painted by Sargent in 1905. Up to then they had apparently worked in harmony. Shortly thereafter they divided two against two in a fight which almost tore the medical school apart. This was over placing the heads of the clinical departments on full time. It was a struggle between laboratory men and clinicians for control of the school. Osler and Kelly headed the clinicians; Welch, Halsted, and Mall the laboratory men. This, briefly, is what happened.

Simon Flexner was a pupil and agent of Welch. His younger brother Abraham, undoubtedly guided by Welch, made a study of medical education in this country, a report of which he published in 1910. This closed half the medical schools in North America. Abraham Flexner next, and again with the assistance of Welch, made a study of the Hopkins Medical School. The resulting report criticized the administration of the clinical departments and advocated placing them under full-time professors. This was bitterly resented by the clinicians. Osler wrote President Remsen as follows: "There is something very attractive in the parallel between the problems of the laboratory and those of the hospital . . . but only a very narrow view regards the director of a university clinic as chiefly an agent for research. He stands for other things of equal importance. In life, in word and in deed he is an exemplar to the young men about him, students and assistants. 'Cabined, cribbed, confined' within the four walls of a hospital, practicing the fugitive and cloistered virtues of a clinical monk, how shall he forsooth train men for a race of the dust and heat of which he knows nothing and—this is a possibility!—cares less? I cannot imagine anything more subversive to the highest ideals of a clinical school than to hand over young men who are to be our best practitioners to a group of teachers who are ex officio out of touch with the conditions under which these young men will live . . . . The danger would be the evolution throughout the country of a set of clinical prigs the boundary of whose horizon was the laboratory and whose only human interest was research . . . . To say, for example, that, as contrasted with the instructors on the laboratory side, the clinical staff has been on the whole less productive and less devoted is simply not true. I deny the statement in toto—they have been more productive and quite as devoted."

Welch regarded this fight at Hopkins as the first battle in a war to wrest control of medical education from clinicians and place it in the hands of laboratory workers. In 1913, while acting president of the Johns Hopkins University, he completed the arrangement with the Rockefeller General Education Board which established Medicine, Surgery and Pediatrics as the first fully endowed full-time clinical departments in an American Medical School. Welch had won the battle and he soon won the war, for most other schools followed the example of Hopkins. And this is how clinicians lost control of medical education.

The annual meeting of the Indiana Heart Foundation will be held on Sunday, October 15, 1950, at 2:00 p.m. in the Lincoln Hotel, in Indianapolis. All members are asked to attend, and all physicians interested in cardiology are cordially invited.

THURMAN B. RICE AUDITORIUM

ANNOUNCEMENT that the auditorium in the new two million dollar State Board of Health building, 1330 West Michigan Street, Indianapolis, is to be known as the "Thurman B. Rice Auditorium," in honor of Dr. Thurman B. Rice, chairman and professor of public health, Indiana University School of Medicine, featured the building dedication program last July 14.

A bronze plaque bearing the inscription "Thurman B. Rice Auditorium," purchased by the employees of the State Board of Health, is to be erected near the entrance to the auditorium.

The announcement was made by Dr. L. E. Burney, state health commissioner, who said:

"Doctor Rice's earliest association with the State Board of Health was late in 1917 when, as a sophomore medical student, he was hired on a part-time basis to wash glassware for the laboratory at 25 cents an hour. For purposes of contrast it is too bad we cannot have a before-and-after picture, for then the laboratories occupied a small spot in the old Gallup Building, where the Harrison Hotel now stands. To get back to our story, after a couple of weeks of this discouraging work he was given a job at a microscope examining slides for gonococcus, tubercle bacillus, diphtheria bacillus, or whatever might arise. The pay was only a little better, but the work was much more agreeable, and he could feel as if he were learning something.

"After Doctor Rice was graduated from medical school in 1921 at the top of his class, he assisted in the Department of Pathology. Doctor Hurty suggested to Dean Emerson that Doctor Rice also teach courses in public health and preventive medicine, since he was already teaching these subjects in the extension division of the university. Doctor Emerson was very much interested in public health, regarding it as 'the advancing edge of medicine.' The teaching of public health has become increasingly important in the medical school until in 1947 a separate department was set up. Prior to that time Doctor Rice had been head of the combined Department of Bacteriology and Public Health. As this new department develops they hope to train in a very practical way the many health workers so urgently needed in the state.

"After Doctor Hurty's death in 1925, Doctor Rice took over a class in the dental college that he had had for nearly a half century. Since 1933 Doctor Rice has been editor of the State Board of Health *Monthly Bulletin*, there having been only three editors since 1896: Hurty, King, and Rice. This is just one of his many 'goatfeathers,' a term only he can define well.

"In the 1930's Doctor Rice spearheaded a movement for separate quarters for the State Board of Health to be located at the Medical Center. In December, 1939, the staff moved into its new building in the heart of the campus. This was particularly important because it has led to far greater cooperation between the medical and health staffs. This set-up is the envy of public health workers in other states.

"Before being named acting state health commissioner, in 1942, Doctor Rice had served as director of the laboratories, state epidemiologist, and director of the Division of Health and Physical Education. In his spare time through the years he has devoted long hours of barnstorming the state, giving health talks. It would be no exaggeration to say that he has spoken at every crossroads meeting place in Indiana—and some of them many times. From his typewriter have rolled thousands upon thousands of words—editorials, poems, articles, and books on the subject of health. He is almost as well known, and as greatly respected, abroad as he is among us Hoosiers.

"As health commissioner, Doctor Rice embarked upon an ambitious legislative program aimed toward reorganizing the State Board of Health, setting up the Advisory Health Council, health departments, and developing a strong Department of Public Health in the School of Medicine. All this was in addition to the emergency legislation. What could be more important than promoting and maintaining public health? Every purpose of government is dependent upon a state of bounding health in its citizens. At that time Steve Noland, then editor of *The Indianapolis News*, characterized Doctor Rice as a visionary dreamer with his head well into the clouds, but his feet planted firmly on the ground. At least some of these long-range objectives have become realities.

"We have come a long way since November 3, 1881."

Dr. Jacob T. Oliphant of Farmersburg is chairman of the State Board of Health. Other members include Dr. Harry P. Ross of Richmond and Dr. Russell W. Lavengood of Marion.

One Hundred And First

Annual Session

Indiana State Medical Association

French Lick, Indiana

September 25, 26 and 27, 1950

Headquarters—French Lick Springs Hotel

Complete program on following pages

C. S. BLACK, M.D.
Warren

PRESIDENT
INDIANA STATE MEDICAL ASSOCIATION
1949-50

INDIANA STATE MEDICAL ASSOCIATION

Officers - 1950

ALFRED ELLISON
President-Elect
South Bend

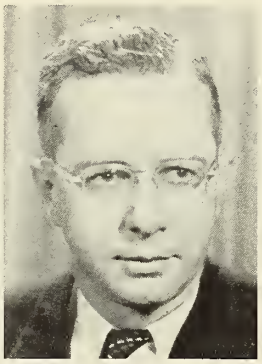
A. F. WEYERBACHER
Treasurer
Indianapolis

MRS. D. E. LYBROOK
President of the Woman's
Auxiliary to the Indiana
State Medical Association
Galveston

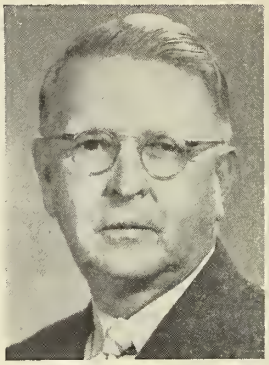
E. M. SHANKLIN
Editor Emeritus
THE JOURNAL
Hammond

FRANK B. RAMSEY
Editor
THE JOURNAL
Indianapolis

A. W. CAVINS
Associate Editor
THE JOURNAL
Terre Haute



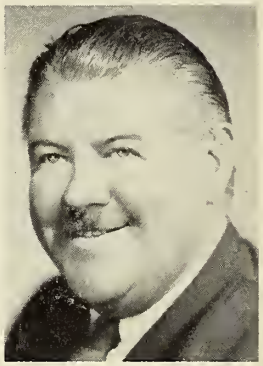
WM. M. COCKRUM
Co-chairman
Convention Arrangements
Evansville



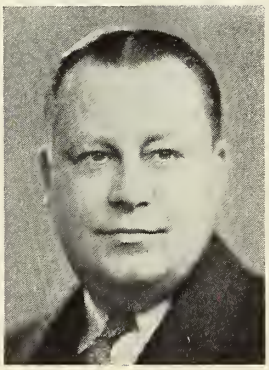
C. E. BOYD
Co-chairman
Convention Arrangements
West Baden

WALTER U. KENNEDY
Chairman of the Council
New Castle

W. L. PORTTEUS
Chairman
Executive Committee
Franklin



CYRUS J. CLARK
Executive Committee
Indianapolis

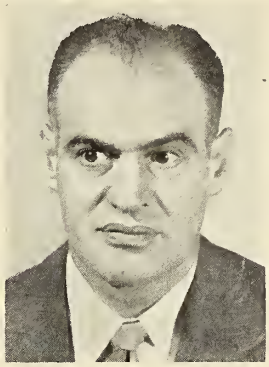


RAY E. SMITH
Executive Secretary and
Managing Editor of
THE JOURNAL
Indianapolis

J. A. WAGGENER
Field Secretary
Indianapolis

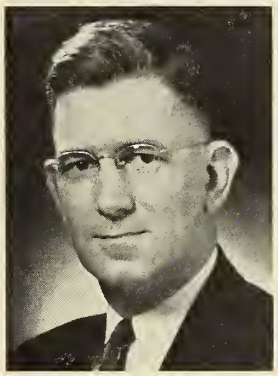
DAVID A. BICKEL
Chairman
Section on Obstetrics and Gynecology
South Bend

C. H. ROMMEL
Chairman
Section on General Practice
West Lafayette



PAUL J. FOUTS
Chairman
Section on Medicine
Indianapolis

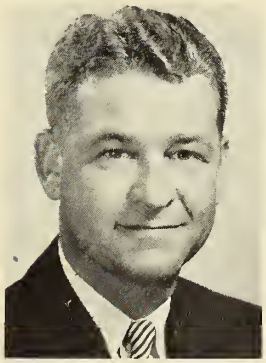
H. C. WALLACE
Chairman
Section on Surgery
Crawfordsville



WILLIAM B. ADAMS
Chairman
Section on Anesthesia
Muncie

DILLON D. GEIGER
Chairman
Section on Ophthalmology and Otolaryngology
Bloomington

WM. D. PROVINCE
Secretary
Section on Medicine
Franklin



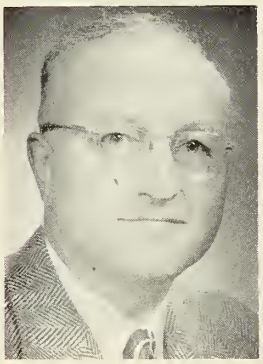
NORMAN F. RICHARD
Secretary
Section on Surgery
Shelbyville

CHARLES L. WISE
Secretary
Section on General Practice
Camden

EDWIN W. DYAR
Secretary
Section on Ophthalmology
and Otolaryngology
Indianapolis

C. O. McCORMICK, JR.
Secretary
Section on Obstetrics
and Gynecology
Indianapolis

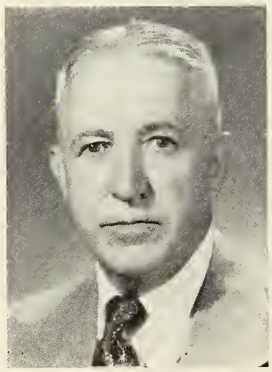
VIRGIL K. STOELTING
Secretary
Section on Anesthesia
Indianapolis



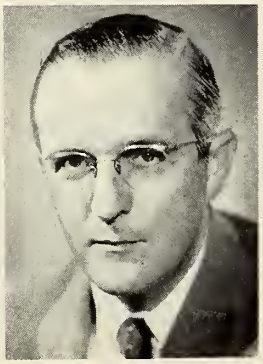
DAVID A. BICKEL
Editorial Board
South Bend

JACOB T. OLIPHANT
Editorial Board
Farmersburg

K. G. KOHLSTAEDT
Editorial Board
Indianapolis



E. L. CARTWRIGHT
Editorial Board
Fort Wayne



STEPHEN L. JOHNSON
Editorial Board
Evansville

RAYMOND F. CARMODY
Editorial Board
Gary

Official Program

One Hundred and First Annual Session

INDIANA STATE MEDICAL ASSOCIATION

French Lick Springs Hotel

French Lick, Indiana

September 25, 26 and 27, 1950

Monday, September 25, 1950

Morning

8:00 a.m. Registration starts, mezzanine floor.

8:00 a.m. Annual golf tournament. Eighteen holes, low gross, low net, and blind bogie medal play. French Lick Hill Course.

9:00 a.m. Opening of technical exhibit, mezzanine floor.

9:00 a.m. Opening of scientific exhibit, foyer to main convention hall.

9:00 a.m. Annual trap and skeet shoot, French Lick Springs Trap and Skeet Club.

10:00 a.m. Editorial Board meeting, Room 143, main floor.

11:00 a.m. Instructional courses.

11:00 a.m. Council meeting, Blue Room.

Afternoon

1 to 5 p.m. Instructional courses.

3:00 p.m. Meeting of House of Delegates, main convention hall. (All Association members are welcome.)

5:00 p.m. Twentieth anniversary meeting of 1930 class of Indiana University School of Medicine, Game Room.

Evening

7:00 p.m. Supper, smoker and stag party, main dining room.

8:30 p.m. Stag party entertainment, main convention hall.

Tuesday, September 26, 1950

Morning

7:30 a.m. Breakfast meeting of members of the State and County Conservation of Vision Committees. Blue Room.
Speaker: JOHN J. FLICK, M.D., Indianapolis.
Subject: "Ocular Casualties in Atomic Warfare."

7:30 a.m. Breakfast meeting of officers, board of directors and chairmen of committees of the Indiana Academy of General Practice, Parlor A.

8:00 a.m. Registration continues, mezzanine floor.

9:00 a.m. Technical exhibit, mezzanine floor.

9:00 a.m. Scientific exhibit, foyer to main convention hall.

GENERAL MEETING

(Main Convention Hall)

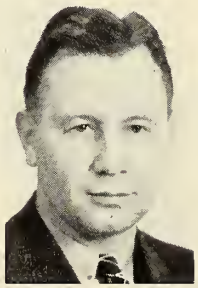
10:00 a.m. Call to order by C. S. Black, M.D., Warren, president, Indiana State Medical Association.

10:05 a.m. Greetings by C. E. Boyd, M.D., West Baden Springs, and William M. Cockrum, M.D., Evansville, co-chairmen of Committee on Convention Arrangements.

10:10 a.m.

J. NEILL GARBER, M.D., Indianapolis.
Subject: "Orthopedic Aspects of Arthritis."

10:30 a.m.



EDGAR S. GORDON, M.D., Associate Professor of Medicine, University of Wisconsin Medical School, Madison, Wisconsin.
Subject: "Newer Developments in Arthritis Therapy."

10:50 a.m. Question and answer period.

11:40 a.m. President's address, C. S. BLACK, M.D., Warren.

(Tuesday, September 26, 1950)

Noon

12 m. Meeting of Section on Obstetrics and Gynecology, main convention hall. Election of section officers for 1951.

12 m. Section on General Practice luncheon, main dining room.

Speakers: CHARLES C. CRAMPTON, M.D., Delphi, Indiana General Practitioner of 1949—"Remarks."

ANDY HALL, M.D., Mount Vernon, Illinois, National General Practitioner of 1949—"Extemporaneous Remarks."
Election of section officers for 1951.

12 m. Luncheon meeting of members of State and County Tuberculosis Committees, Round Room. Indiana Chapter of American College of Chest Physicians participating.

Speaker: J. VINCENT SHERWOOD, M.D., Fort Wayne.

Subject: "The A/G Ratio Correlated with Pulmonary Tuberculosis."
X-ray conference.

Afternoon

GENERAL MEETING

2:00 p.m. Panel discussion: "Total Hysterectomy vs. Subtotal Hysterectomy in Benign Lesions of the Fundus."

Moderator: DAVID A. BICKEL, M.D., South Bend.
10 minutes each:

CARL P. HUBER, M.D., Chairman, and Professor of Obstetrics and Gynecology, Indiana University School of Medicine, Indianapolis.

Dr. Bickel

Dr. Huber

(Tuesday, September 26, 1950)

W. D. INLOW, M.D., Shelbyville.
JAMES M. McFADDEN, M.D., LaFayette.

Dr. Inlow

Dr. McFadden

2:30 p.m. Question and answer period.

3:00 p.m. Thirty-minute intermission. Time allowed to view scientific and technical exhibits.

3:30 p.m.

DAVID A. BOYD, Jr., M.D., Professor of Psychiatry, University of Minnesota Graduate School, Mayo Foundation, Rochester, Minnesota.

Subject: "The Psychological Language of the Organs."

3:50 p.m.

MORTIMER MANN, M.D., Indianapolis.

Subject: "Ocular Fundus Manifestations of General Disease."

4:10 p.m.

HAYES MARTIN, M.D., Associate Professor of Clinical Surgery, Cornell University Medical College, New York.

Subject: "The Diagnostic Significance of a 'Lump in the Neck.'"

4:30 p.m. Meeting of Section on Ophthalmology and Otolaryngology, main convention hall. Election of section officers for 1951.

4:30 p.m. Time allowed to view scientific and technical exhibits.

Evening

9:00 p.m. Dance, with name band, main convention hall.

Wednesday, September 27, 1950

Morning

7:30 a.m. Breakfast meeting of Committee on Conference of County Medical Society Officers, Parlor A.

7:30 a.m. Breakfast meeting of Committee on Industrial Health, Parlor B.

8:00 a.m. Registration continues, mezzanine floor.

9:00 a.m. Technical exhibit, mezzanine floor.

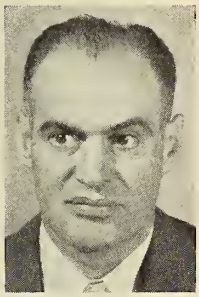
9:00 a.m. Scientific exhibit, foyer to main convention hall.

10:00 a.m. Meeting of Indiana Association of Pathologists, Radio Room.

GENERAL MEETING

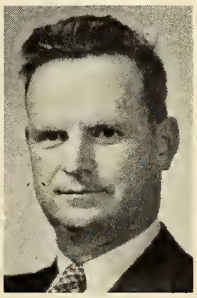
(Main Convention Hall)

10:00 a.m. Panel discussion: "Uses and Abuses of Antibiotics and Antihistamines."
Moderator: PAUL J. FOUTS, M.D., Indianapolis.
10 minutes each:
KENNETH L. CRAFT, M.D., Indianapolis. (Ear, nose and throat.)
KENNETH T. KNODE, M.D., South Bend. (Pediatrics.)
HUGH A. KUHN, M.D., Hammond. (Eye.)


Dr. Fouts

Dr. Craft

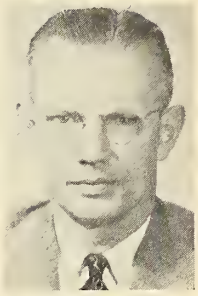
Dr. Knode


Dr. Kuhn

(Wednesday, September 27, 1950)

GEORGE W. WILLISON, M.D., Evansville. (Internal Medicine.)
MAURICE S. FOX, M.D., Vincennes. (Allergy.)

Dr. Willison


Dr. Fox

10:50 a.m. Question and answer period.

11:30 a.m. Final meeting of the House of Delegates, west dining room. Annual election of officers and selection of convention city for 1952. (Luncheon meeting.)
Meeting of Council immediately following adjournment of House of Delegates.

11:45 a.m. Meeting of Section on Medicine, main convention hall. Election of section officers for 1951.

11:45 a.m. Time allowed to view scientific and technical exhibits.

Noon

12 m. Luncheon meeting of Section on Anesthesia, Blue Room.
Speaker: R. M. S. BARRETT, M.D., St. Louis.
Election of section officers for 1951.

12 m. Phi Beta Pi luncheon meeting, Round Room.

12 m. Luncheon meeting of 1935 class of Indiana University School of Medicine, Parlors A and B.

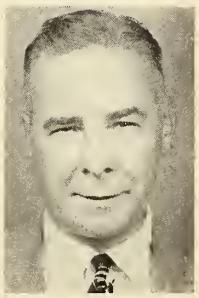
Afternoon

GENERAL MEETING

(Main Convention Hall)

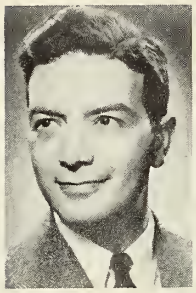
2:00 p.m.

R. M. S. BARRETT, M.D., Senior Instructor in Surgery (Anesthesia), St. Louis University School of Medicine, St. Louis.
Subject: "Anesthesiology—Its Economics."



(Wednesday, September 27, 1950)

2:20 p.m.



HARRIS B. SHUMACKER, Jr., M.D., Chairman, and Professor of Surgery, Indiana University School of Medicine, Indianapolis.
Subject: "The Potentialities and Limitations of Sympathetic Nerve Surgery."

2:40 p.m.

DONALD C. McCLELLAND, M.D., LaFayette.
Subject: "X-ray Diagnosis for the General Practitioner."

3:00 p.m. Thirty-minute intermission. Time allowed to view scientific and technical exhibits.

3:30 p.m.

FRANCIS E. SENEAR, M.D., Professor of Dermatology, University of Illinois College of Medicine, Chicago. (Brayton Foundation speaker.)
Subject: "Eczema of the Hand."

3:50 p.m.

OWEN H. WANGENSTEEN, M.D., Professor of General Surgery, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis - Rochester.
Subject: "Intestinal Obstruction."

(Wednesday, September 27, 1950)

4:10 p.m.

S. LEON ISRAEL, M.D., Philadelphia.
Subject: "The Modern Treatment of Sterility."

4.30 p.m. Meeting of Section on Surgery, main convention hall. Election of section officers for 1951.

4:30 p.m. Women Physicians' Tea, Parlor A.

4:30 p.m. Time allowed to view scientific and technical exhibits.

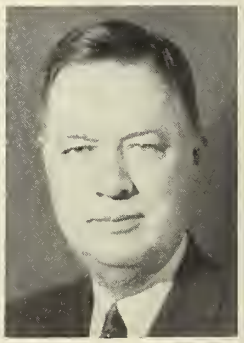
Evening

6:30 p.m. Annual banquet, main dining room.
Presiding officer, C. S. BLACK, M.D., president, Indiana State Medical Association.

Presentation of certificate of merit and plaque to AUGUSTUS P. HAUSS, M.D., president 1949, by C. S. Black, M.D.

Recognition of Fifty-Year Club members.
Award to General Practitioner of the Year.

Speakers:



ELMER L. HENDERSON, M.D., president, American Medical Association, Louisville.

HENRY P. THROCKMORTON, Boston.

Presentation of certificate of merit and plaque to C. S. BLACK, M.D., president 1950, by Alfred Ellison, M.D.

Evansville Scottish Rite choir.

Women's Entertainment

Monday, September 25, 1950

9:00 a.m. Registration starts, mezzanine floor.

6:30 p.m. Dinner, honoring past presidents of Woman's Auxiliary to the Indiana State Medical Association, west dining room. Entertainment in main dining room.
Speaker:

ERNESTINE GILBRETH CAREY, Co-author of "Cheaper by the Dozen," and "Belles on Their Toes."

Concert Pianist: SHIRLEY LANGSNETHEN

Tuesday, September 26, 1950

8:30 a.m. Golf tournament, French Lick Valley Course. Prizes.

9:00 a.m. Registration continues, mezzanine floor.

10:00 a.m. Board meeting, Woman's Auxiliary to the Indiana State Medical Association, Room 142, main floor.

2:00 p.m. Bridge and Canasta, North Porch. Prizes.

9:00 p.m. Dance, main convention hall, in conjunction with the Indiana State Medical Association.

Wednesday, September 27, 1950

9:00 a.m. Registration continues, mezzanine floor.

9:00 a.m. House of Delegates (continuation of spring session), North Convention Hall. General business meeting.

12:30 p.m. Luncheon, main dining room.
Humorist: FOREST "DOC" TRAYLOR.
Music by Indiana University entertainers.
Speaker: ELMER L. HENDERSON, M.D., president, American Medical Association, Louisville.

2:30 p.m. School of Instruction, Game and radio rooms.
Round table discussion led by chairmen of standing committees.

6:30 p.m. Annual banquet in conjunction with the Indiana State Medical Association, main dining room.

Program

INDIANA STATE HEALTH OFFICERS' ASSOCIATION

FRENCH LICK SPRINGS HOTEL
FRENCH LICK
SUNDAY, MONDAY—SEPTEMBER 24-25
DAYLIGHT SAVING TIME

Sunday, September 24, 1950

12:30 p.m.-1:45 p.m.—Registration
Presiding—L. E. BURNEY, M.D.
State Health Commissioner
Indiana State Board of Health

1:45- 2:00—Welcome and Introductory Remarks

2:00- 2:50—*A Practical Method of Garbage and Refuse Disposal*
MR. ALBERT KLATTE
Indiana State Board of Health
Small Water Supplies and Sewerage Systems
MR. ROBERT S. LEECH
Indiana State Board of Health

2:50- 3:20—Discussion
(Representatives of the Environmental Sanitation Bureau will be available to answer questions regarding the problems of sanitation.)

3:20- 3:30—Recess

3:30- 4:00—*Current Immunization Procedures*
GEORGE M. BROTHER, M.D.
Director Bureau of Preventive Medicine
Indiana State Board of Health

4:00- 4:15—*Purpose and Functions of Regulations*
ROBERT HOLLOWELL, Attorney
Indiana State Board of Health

4:15- 5:00—Discussion

Monday, September 25, 1950

Breakfast to be held at 8:00 A.M.
Presiding—MORRIS BALLA, M.D.
President, State Health Officers' Association

9:00- 9:30—Business meeting

9:30-12:00—Open Discussion
(Topics will be of current interest. All members of the assocation will be urged to participate.)

OFFICIAL CALL TO THE HOUSE OF DELEGATES

The next annual session of the Indiana State Medical Association will be held at French Lick, September 25, 26 and 27, 1950.

The House of Delegates will be constituted as follows: Marion County, seventeen delegates; Lake County, six delegates; Allen County, four delegates; St. Joseph County, four delegates; Vanderburgh County, four delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Jasper-Newton, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union County Societies, each two delegates; the other sixty-three county societies, each one delegate; thirteen councilors; and the ex-presidents, namely: C. S. Bond, W. H. Stemm, E. M. Shanklin, Charles N. Combs, George R. Daniels, Charles E. Gillespie, F. S. Crockett, J. H. Weinstein, E. E. Padgett, R. L. Sensenich, Herman M. Baker, Karl R. Ruddell, A. M. Mitchell, M. A. Austin, Carl H. McCaskey, J. T. Oliphant, N. K. Forster, J. E. Ferrell, Floyd T. Romberger, Cleon A. Nafe and Augustus P. Hauss; and ex-officio, the president, president-elect, executive secretary, and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to Ray E. Smith, 1021 Hume Mansur Building, Indianapolis 4, Indiana, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 3:00 P.M., Monday, September 25, in the main convention hall, French Lick Springs Hotel, and again at 11:30 A.M., Wednesday, September 27, in the west dining room, French Lick Springs Hotel. (Luncheon meeting.)

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Address of president-elect.
6. Report of executive secretary.
7. Report of the treasurer.
8. Report of the chairman of the Council.
9. Reports of councilors.
10. Reports of standing and special committees:
    - (1) Executive Committee.
    - (2) Constitution and By-Laws.
    - (3) Convention Arrangements.
    - (4) Industrial Health.
    - (5) Medical Education and Hospitals.
    - (6) Public Policy and Legislation.
    - (7) Public Relations.
    - (8) Sub-Committee on Grievances.
    - (9) Publicity.
    - (10) Scientific Exhibits.
    - (11) Scientific Work.
    - (12) Auditing.
    - (13) Cancer.
    - (14) Conference of County Medical Society Officers.
    - (15) Conservation of Vision.
    - (16) Crippled Children Services.
    - (17) Diabetes.
    - (18) Hard of Hearing.
    - (19) Heart Disease.
    - (20) Indiana A.M.A. Campaign Coordinating Committee.
    - (21) Indiana Inter-Professional Health Council.
    - (22) Infantile Paralysis.
    - (23) Instructional Courses.
    - (24) Maternal and Child Health.
    - (25) Medical and Nursing School Scholarships.
    - (26) Mental Health.
    - (27) Necrology.
    - (28) Prepaid Medical and Hospital Insurance.
    - (29) Rural Health.
    - (30) School Health and Physical Education.
    - (31) State Fair.
    - (32) Traffic Safety.
    - (33) Tuberculosis.
    - (34) Venereal Disease.
    - (35) Veterans Affairs and Rehabilitation.
    - (36) Journal Publication.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1950, and their successors must be elected at the session: Delegates to the American Medical Association to succeed H. G. Hamer, Indianapolis, and A. S. Giordano, South Bend; and alternates, Karl R. Ruddell, Indianapolis, and E. S. Jones, Hammond.

Delegates from the first, fourth, seventh, tenth and thirteenth districts are reminded that the terms of their councilors will expire December 31, 1950, and new councilors should be elected to succeed the following:

First District: Herman T. Combs, Evansville.
Fourth District: George A. May, Madison.
Seventh District: Roy A. Geider, Indianapolis.
Tenth District: William H. Howard, Hammond.

Thirteenth District: Kenneth L. Olson, South Bend.

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

RAY E. SMITH, *Executive Secretary*

Reports of Officers and Committees

EXECUTIVE SECRETARY

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The year 1949-50 has been a period of action for the Indiana State Medical Association. An extensive educational campaign against government-controlled medicine has been carried on throughout the state, for which the association has won national recognition. Every Indiana physician can be proud of his association's success in this field.

Twenty years ago the Indiana State Medical Association had only 2,737 members and fourteen committees. The membership at the end of the last calendar year was 3,759 and thirty-six committees were functioning. These figures illustrate the growth of the organization. Activities and problems of the association were very limited in 1930, but with the increasing years the scope of activity of the association has broadened in direct relationship to the mounting problems of medicine.

Addition of the field secretary and another stenographer to the association's full-time staff became necessary in order to meet the growing demands upon the headquarters office. This extra personnel has enabled the association to indulge in extra activities, such as the aggressive fight against compulsory sickness insurance.

The entire headquarters staff of seven full-time employees is working hard and doing its level best to serve the Indiana medical profession loyally and efficiently.

RAY E. SMITH, *Executive Secretary.*

TREASURER

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The following report, prepared by George S. Olive and Company of Indianapolis, gives the financial status of the association as of December 31, 1949. The bank balances as of July 31, 1950, are contained in the report of the Auditing Committee which will be found on page 899.

The accountant's report is as follows:

January 13, 1950

The Council,
Indiana State Medical Association,
Indianapolis, Ind.

Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association as of December 31, 1949, and the statements of income and expense, and fund balances for the year then ended, on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, subject to the comments contained in this report, the accompanying statement of assets, all funds, and related statements of income and expense, on the basis of cash received and disbursed, present fairly the position of the Indiana State Medical Association at December 31, 1949, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

GENERAL COMMENT

In exhibit A is presented an analysis of the decrease in assets of the Association for the year ended December 31, 1949, showing in summary form the sources from which this decrease was derived.

A decrease of $6,931.93 in assets of the general fund resulted from an excess of operating cash disbursements over operating cash receipts.

Exhibit C presents a comparative analysis of the cash receipts and disbursements for the years ended December 31, 1949, and December 31, 1948. Total receipts increased $19,281.20, and total disbursements increased $31,129.77 over the preceding year.

Details of the assets of all funds are presented in exhibit B. There were no recorded liabilities at December 31, 1949, and the assets shown represent the surplus of each fund at that date. We have examined securities of the Association, which are kept in the Association's safe deposit box in the Indiana National Bank. Cash on deposit was confirmed by direct correspondence with the depositories.

Analyses of the cash receipts and disbursements of the general fund, of The Journal of the Indiana State Medical Association, and of the Medical Defense fund are presented in exhibits C, D, and E, respectively.

Yours very truly,
Geo. S. Olive & Co.
Certified Public Accountants.

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION
Analysis of Decrease in Assets, All Funds, Year Ended December 31, 1949

TOTAL ASSETS, DECEMBER 31 1949— Exhibit B	$72,678.56
TOTAL ASSETS, DECEMBER 31, 1948	80,646.23
NET DECREASE	$ 7,967.67

Arising from the following sources:			
Excess of operating cash disbursements over operating cash receipts, general fund, year ended December 31, 1949:			
Receipts—			
Exhibit C	$87,159.64		
Disbursements—			
Exhibit C	94,391.57		
		7,231.93	
Increase in petty cash fund		300.00	
			$6,931.96
Excess of operating cash disbursements over operating cash receipts, The Journal of the Indiana State Medical Association, year Ended December 31, 1949:			
Receipts—			
Exhibit D	43,676.21		
Disbursements—			
Exhibit D	44,652.95		
			976.74
Excess of operating cash disbursements over operating cash receipts, Medical Defense fund, year ended December 31, 1949:			
Receipts—			
Exhibit E	3,041.00		
Disbursements—			
Exhibit E	3,100.00		
			59.00
NET DECREASE			$ 7,967.67

Exhibit B

INDIANA STATE MEDICAL ASSOCIATION

Statement of Assets, All Funds, at December 31, 1949

GENERAL FUND:			
Cash on deposit——Exhibit C		$ 8,964.01	
Petty cash fund		500.00	
Investments:			
Indianapolis City Hospital Bonds	$ 5,000.00		
U. S. Treasury bonds	5,000.00		
U. S. Savings bonds	31,000.00		
		41,000.00	
Total general fund			$50,464.01
THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:			
Cash on deposit—Exhibit D			4,822.83
MEDICAL DEFENSE FUND:			
Cash on deposit—Exhibit E		2,391.72	
U. S. Treasury bonds	5,000.00		
U. S. Savings bonds	7,000.00		
U. S. Baby bonds	3,000.00		
		15,000.00	
Total Medical Defense fund			17,391.72
TOTAL ASSETS, ALL FUNDS—Exhibit A			$72,678.56

Exhibit C

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Cash Receipts and Disbursements, Years Ended December 31, 1949, and December 31, 1948

	Year Ended Dec. 31 1949	Year Ended Dec. 31, 1948	Increase (Decrease)
CASH BALANCE AT BEGINNING OF YEAR	$16,195.94	$11,579.30	$ 4,616.64
RECEIPTS:			
Membership dues	53,300.00	52,039.00	1,261.00
Income from exhibits	15,080.00	12,676.23	2,403.77
Interest income:			
U. S. Treasury bonds	212.50	212.50	------
U. S. Savings bonds	625.00	437.50	187.50
Indianapolis, Indiana, City Hospital bonds	200.00	200.00	------
Marion County, Inana, Flood Prevention bonds	127.50	127.50	------
Krannert Nurse Scholarship fund	------	800.00	(800.00)
Egbert Medical Scholarship fund	------	200.00	(200.00)
Centennial book fund	357.20	930.80	(573.60)
Instructional courses	239.94	197.83	42.11
Other refunds	------	57.08	(57.08)
A.M.A. campaign fund	17,000.00	------	17,000.00
Checks written off	17.50	------	17.50
	87,159.64	67,878.44	19,281.20
BEGINNING BALANCE PLUS CASH RECEIPT	103,355.58	79,457.74	23,897.84
DISBURSEMENTS:			
Transfer of applicable portion of dues to The Journal of The Indiana State Medical Association—Exhibit D	11,213.00	10,970.00	243.00
Permanent transfer of funds to The Journal	3,000.00	------	3,000.00
Medical Defense fund —Exhibit E	2,691.00	2,630.25	60.75
Purchase of securities	------	10,000.00	(10,000.00)
Headquarters office expense	26,837.25	16,792.58	10,044.67
Publicity committee	1,068.44	1,361.00	(292.56)
Public policy	2,265.62	1,483.26	782.36
Council	1,076.55	1,750.79	(674.24)
Officers	3,538.79	639.33	2,899.46
Annual session	17,865.81	7,867.28	9,998.53
Miscellaneous committees	14,363.03	7,386.90	6,976.13
Federal insurance contributions	139.63	81.88	57.75
Indiana unemployment compensation and excise tax	483.38	------	483.38
Postgraduate study	------	456.04	(456.04)
Refunds of dues	------	12.00	(12.00)
Refunds on exhibit rent	------	181.25	(181.25)
Fifty-Year Club	176.91	234.67	(57.76)
Increase in petty cash fund	300.00	------	300.00

Women's Auxiliary to the I.S.M.A.	800.00	800.00	------
Indiana A.M.A. Campaign Coordinating Committee	8,511.55	------	8,511.55
General practitioner award	60.61	61.01	(.40)
Instructional courses	------	2.00	(2.00)
Field secretary	------	551.56	(551.56)
	94,391.57	63,261.80	31,129.77
CASH BALANCE AT END OF YEAR	$ 8,964.01	$16,195.94	$(7,231.93)

Exhibit D

INDIANA STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Year Ended December 31, 1949

The Journal of The Indiana State Medical Association

BALANCE JANUARY 1, 1949		$ 5,799.57
RECEIPTS:		
Subscriptions — members — Exhibit C	$11,213.00	
Subscriptions—non-members	496.00	
Permanent transfer of funds from General Fund	3,000.00	
Advertising	27,790.33	
Collections on accounts receivable	357.09	
Single copy sales	154.50	
Electrotypes	584.81	
Miscellaneous	80.48	
Total receipts—exhibit A		43,676.21
		49,475.78
DISBURSEMENTS		
Salaries	11,534.63	
Printing	28,572.41	
Office postage	157.71	
Journal postage	636.05	
Advertising commissions	186.60	
Electrotypes	1,420.17	
Press clippings	60.13	
Editor and editorial board expense	266.07	
Office supplies	272.18	
Rent	480.00	
Electricity	32.87	
Telephone and Telegraph	207.42	
Federal insurance contributions	97.21	
Insurance	316.00	
Indiana Unemployment compensation and excise tax	231.19	
Miscellaneous	182.31	
Total Disbursements—Exhibit A		44,652.95
BALANCE, DECEMBER 31, 1949 —Exhibit B		$ 4,822.83

Exhibit E

INDIANA STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements, Year Ended December 31, 1949
Medical Defense Fund

BALANCE, JANUARY 1, 1949			$ 2,450.72
RECEIPTS:			
Transfer of applicable portion of dues from the general fund—Exhibit C		$ 2,691.00	
Interest income:			
U. S. Treasury bonds	$140.00		
U. S. Savings bonds	125.00		
Marion County Flood Prevention bonds	85.00		
		350.00	
Total receipts—Exhibit A			3,041.00
			5,491.72
DISBURSEMENTS:			
Malpractice fees		1,262.50	
Attorney fees		1,800.00	
Treasurers bond		37.50	
Total disbursements—Exhibit A			3,100.00
BALANCE, DECEMBER 31, 1949 —Exhibit B			$ 2,391.72

A. F. WEYERBACHER, M.D., *Treasurer*

CHAIRMAN OF THE COUNCIL

House of Delegates,
Indiana State Medical Association.

Gentlemen:

As minutes of all Council meetings held the past year have appeared in THE JOURNAL, and are being submitted to the Reference Committee for its information, it is unnecessary for me to go into extended detail on Council actions. Only a few of the major decisions of the Council will be mentioned.

A change in the chairmanship of the Council occurred at the conclusion of the 1949 annual convention. Dr. Alfred Ellison of South Bend, having been elected president-elect, resigned. I wish to pay tribute to the excellent manner in which Doctor Ellison conducted the meetings of the Council during his three years as chairman.

The Council filled the office of assistant treasurer, created by the House of Delegates, by election of Dr. Roy V. Myers of Indianapolis.

The Council is recommending to the delegates that two amendments be made to the By-Laws. The amendments, which will be submitted by the Committee on Constitution and By-Laws, (1) permits the Council to excuse a member from paying state dues on recommendation of his county

society and for good cause, and (2) requires American citizenship or holding of first naturalization papers as a requisite for membership in the Indiana State Medical Association.

After a committee of the Council made an extensive study of the feasibility of offering a retirement income plan to the membership, the Council approved the committee's recommendation that the proposition of the Jefferson National Life Insurance Company be accepted.

The Council received a report from a delegates-created committee to study training of girls to do simple laboratory procedures because of the need for talent in this field. The committee recommended a long-range program which the Council approved.

The Council has been much concerned about the set-up for civilian defense and has authorized the Committee on Veterans Affairs and Rehabilitation to see that direction of purely medical measures be kept in the hands of medical men.

A Council committee is now developing a method for evaluating health and accident insurance policies so that members will be protected against inferior and inadequate policies.

All but two councilor districts have elected alternate councilors in accordance with provisions of the new By-Laws. Some alternate councilors are attending the meetings and we welcome them to our deliberations.

The Council meetings are handled with dispatch because of the wholehearted cooperation given the chairman by the members.

WALTER U. KENNEDY, M.D., *Chairman.*

REPORTS FROM DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

The first district has been well organized for the fight against socialized medicine. Vanderburgh, Gibson, Posey and Perry counties have done an excellent job of obtaining resolutions in opposition.

An organization called "The American Way," formed by leading citizens and members of the profession, was active in the primary election in Vanderburgh county and is growing.

The Post Graduate course operated by Vanderburgh County Medical Society was well attended.

Study of the "Topeka Plan" for indigent care is being made by the Vanderburgh County Medical Society for possible operation in the county.

H. T. COMBS, M.D., *Councilor.*

SECOND COUNCILOR DISTRICT

The Second District Medical Society met in the afternoon of May 25 at the Vincennes Country Club, with Dr. Richard Anderson of Vincennes presiding.

Following the dinner meeting a business session was held. Dr. C. Philip Fox of Washington was elected president, Dr. J. S. Brown of Carlisle was reelected secretary, and Dr. Sam Rotman of Jasonville was elected alternate councilor. Washington was chosen as the place for the next meeting.

Papers were presented on "Psychiatry for the General Practitioner," by Dr. James F. Reilly; "Hematuria," by Dr. Norbert M. Welch; "Tumors of the Skin," by Dr. Nathaniel D. Ewing; "Some Facts About X-ray Therapy the General Practitioner Should Know," by Dr. R. G. Moore; and "Differential Diagnosis of Clinical Jaundice," by Dr. Ralph O. Smith.

WILLIAM C. REED, M.D., *Councilor*

THIRD COUNCILOR DISTRICT

The third district held its annual meeting at Jeffersonville, May 17, 1950. It was well attended and we had excellent presentations of scientific papers. Dr. Elmer L. Henderson, president of the A.M.A., was our guest speaker. He brought us up to date on the national fight against Socialized Medicine. Dr. W. U. Kennedy presented the work of the state association in its part to preserve American Medicine.

The Woman's Auxiliary is very active in our district. They have organized on a district level and have been working well with lay groups to bring the story of socialization to them.

We are looking forward to a great state meeting in our district at French Lick in September.

WM. H. GARNER, M.D., *Councilor.*

FOURTH COUNCILOR DISTRICT

The annual meeting of the Fourth District was held May 17, 1950, at Greensburg in the Y.M.C.A. Building, with Dr. Dale D. Dickson, president, presiding. At the House of Delegates meeting a report from the Councilor was heard and discussed. The officers elected for the next year were: President, Dr. B. W. Thayer of North Vernon, and Councilor, Dr. Charles Overpeck of Greensburg. Then followed a fine scientific session which was well attended. A paper on "Respiratory Infections" was presented by Dr. J. O. Ritchey of Indianapolis. Dr. Edward J. Manwell of Northampton, Massachusetts, spoke on "Venous Stasis in the Lower Extremity," and Dr. Charles J. Miller of the Surgery Staff, Memorial Hospital, New

York, gave his interesting paper on "The Cancer Problem as Related to the General Practice of Medicine." Mr. R. S. Saylor of Indianapolis talked on some of the problems of Mutual Medical Insurance, and stressed the point that it needs our support.

The Fourth District was honored by the presence of Dr. Claude S. Black, President of I.S.M.A., who talked on some of his problems in that office.

A sumptuous banquet was well attended in the evening and Mr. Russell Richardson spoke on "Socialism in England." The public was invited to hear this talk.

The entertainment included a golf tournament in the morning for the men, and a tea and book review for the wives.

The next meeting will be held in North Vernon next spring.

GEORGE A. MAY, M.D., *Councilor*

FIFTH COUNCILOR DISTRICT

Each county society in the Fifth District Medical Society is functioning nicely.

The district society held its annual meeting at the Phoenix Country Club on May 17, 1950.

Golf was played in the morning.

In the afternoon there was a scientific session with: Dr. Isadore Kwitney of Indianapolis talking on the differential diagnosis of the pneumonias; Dr. Earl Mericle of Indianapolis talking on psychiatry in general practice; Dr. Frank Teague of Indianapolis talking on disorders of the shoulder joint.

Dr. Basil Merrill of Rockville was elected president; Dr. Gilbert Rhea of Greencastle was elected vice-president; Dr. S. R. Combs of Terre Haute was reelected secretary.

Mr. Ray Smith, executive secretary of the Indiana State Medical Association gave a talk on medical problems of the day.

The next meeting will be held May 9, 1951 at the Phoenix Country Club, Terre Haute.

A. M. MITCHELL, M.D., *Councilor*

SIXTH COUNCILOR DISTRICT

The Sixth District reports a year of harmony, scientific progress and much increased participation in politics and public relations.

Scientific programs have been presented regularly but with a marked increase in attention to social relations. This has been increased by the rapid growth of the medical auxiliary. Improved social relations between the wives of physicians always improves relations between their husbands. If they do nothing more, their organization is justified. But they do more. They actively spread our beliefs in our medical care methods and actively participate in practical politics.

In public relations the physicians of the District have done much, speaking to all kinds of organizations, participating in public movements, establishing special public clinics, such as cancer and T.B., providing "round-the-clock" service, special checkups in pre-school children, all of which has been done in each county of the District.

Liberal expenditures have been made for publicity in addition to the special dues of the state and A.M.A., thus providing for extra newspaper and radio publicity.

We have had the constant support and advice of our Congressman, who has kept us informed of matters affecting our profession, and Representative Harvey's efforts have been ably paralleled by Senators Capehart and Jenner.

If every District kept in as close touch with their Congressional representatives, there would be no national political question for medical men and we could revert back to our accustomed political beliefs, but so long as present conditions remain, we disregard party affiliation to support those who are opposed to socialistic infiltration.

The annual District meeting at Greenfield had the usual excellent program and was honored by the presence of four ex-presidents of the state association. Among them was our own Doctor Ferrell, recovering from a severe illness to the satisfaction of his many friends who appreciate his long years of service to the profession.

We have gone in heavily for meetings to which men of every occupation have been invited, with addresses by outstanding laymen, discussing the inroads of socialism in general, which in the end enlists them in our support.

We had an interesting address at Connersville by the British physician, Doctor Gampell, which the local profession turned into an outstanding public event. Transcription of this address was made which will be offered to each society in the District.

WALTER U. KENNEDY, M.D., *Councilor*

SEVENTH COUNCILOR DISTRICT

Having been elected Councilor of the Seventh District to succeed Dr. C. J. Clark on May 9, 1950, I have not had opportunity to date to become familiar with the duties of the office. It is my observation, supported by conversation with the former Councilor, that everything is moving along satisfactorily in the four counties comprising the District.

ROY A. GEIDER, M.D., *Councilor*

EIGHTH COUNCILOR DISTRICT

The annual meeting of the Eighth District Medical Society was held at Muncie on May 17, 1950. The program and arrangements were made by the Randolph County Society, with Dr. Ivan Brenner in charge of the meeting.

Dr. B. R. Kirklin of Rochester, Minnesota, presented a paper and discussion of hiatus hernia.

Dr. C. E. Martin presented prizes won during the golf tournament played during the afternoon.

Mr. James Waggener from headquarters office was present and spoke regarding the most important activities of the association during the year.

The officers elected for 1951 were: Dr. A. C. Badders, president; Dr. D. E. Spahr, secretary-treasurer; and Dr. T. R. Hayes, alternate councilor.

E. H. CLAUSER, *Councilor.*

TENTH COUNCILOR DISTRICT

During the past year there was greatly increased activity among the physicians in the Tenth District and on the part of the County Societies as organizations, in combating the inroads of Government medicine. Between 75 to 100 organizations of various types invited speakers to discuss this legislation before their groups. This activity resulted in resolutions from the heavy majority of the groups opposing the enactment of these laws. The number of pieces of literature prepared by the American Medical Association's educational campaign distributed in the physicians' offices in Lake County alone exceeded 5,000. This county society also passed out several hundred additionally at its booth at the Lake County Fair. A similar project is being arranged for this year's fair. The Woman's Auxiliary has been exceptionally active, not only in supplying personnel for these booths, but in securing invitations from their own clubs for speakers. I believe we can look forward to another year of this very commendable activity.

The District held two meetings, the first being in October at the Marshall House in Gary. At this meeting Dr. Paul R. Hawley, then chief executive officer of the Blue Cross-Blue Shield Commissions, discussed Socialized Medicine and the need for active effort on the part of every individual physician to meet the threat. The state association's advertising campaign was explained by your Councilor. Also at this meeting Dr. C. W. Yarrington, Gary, was elected District President, and Dr. D. B. Templin, Gary, was elected Secretary. The new office of Alternate Councilor was filled with the election of Dr. J. R. Doty, Gary.

The first meeting of the Tenth District Auxiliary was held concurrently, resulting in the formation of an auxiliary in Jasper-Newton Counties, thus making the Tenth District 100 percent.

The next District meeting was held in April. This meeting was held in four sections, two for the Woman's Auxiliary and two for the physicians. The Auxiliary program included the dedication of a plaque honoring Dr. Henry Palmer, Lake County's first physician, at the site of his first home. Following this a party was held at Sorrento Inn, during which new officers of the Auxiliary were installed.

The physicians' program began at Indiana University Calumet Center with a two-hour program conducted by Indiana University Medical School Faculty covering various scientific subjects. Following this a dinner was held at Phil Smidt's Restaurant. Announcements were read showing that the first 10 months' experience under the new group accident and health insurance policy had resulted in a total payment of claims amounting to $7,511, which ranged individually from $21 to $2,193.

Dr. Ray Modjeski introduced Dr. John D. Van Nuys, Dean of the Indiana University School of Medicine, who discussed the efforts being made at the school to meet the growing need for more physicians in this state.

A series of weekly radio programs entitled "Drama—M.D!" began over radio station WWCA, Gary, in April, which told in story form the accomplishments of medicine and presented our arguments against Government Medicine in dramatized form.

Also during April a two-day school, particularly for nurses, was held in Hammond and Gary under the co-sponsorship of the county societies in this District and the State Board of Health, designed to improve the care of premature infants. This was attended by more than 100 nurses.

In view of the troubled international situation, the program for the coming fall meeting of the District is being arranged with the assistance of the Fifth Army on the subject of atomic energy and its relation to the medical profession. At this time plans for the organization of the profession in this district will be consummated.

WILLIAM H. HOWARD, M.D., *Councilor*

ELEVENTH COUNCILOR DISTRICT

The component societies of the Eleventh Councilor District are all active and holding regular meetings. Most have arranged for round-the-clock emergency coverage. All are active in the fight against compulsory health insurance. The work of the several woman's auxiliaries is to be commended in aiding the round-up of resolutions by various community organizations. We should all be alert in the follow-up and continuance of this work.

The Eleventh District is proud of the honor of supplying from its ranks Dr. Claude S. Black who, with his motto or slogan of "Service," is so ably leading this organization as state president.

Also, we are proud and grateful for the honor of the selection of one of our members as the "Doctor of the Year"—Dr. C. C. Crampton. Both of these men deserve a big hand for achievement.

We have tried very hard to follow the directives from the headquarters office and from the Legislative Committee. These men are doing a fine job, and deserve all the support we can give them in carrying out their recommendations.

Radio Station WIOU (1350) at Kokomo is carrying a series of weekly broadcasts entitled

"Your Doctor," to be heard every Tuesday at 9:45 P.M. These broadcasts are being sponsored by the Howard and Tipton County societies.

Our fall meeting was at Delphi on September 21, 1949, and the spring meeting at Marion at the Veterans' Administration grounds, May 17, 1950. Both meetings were interesting, instructive and well attended. At the latter meeting, officers were elected as follows: President, Dr. L. D. Holliday, Fairmount; Secretary, Dr. Cloyn R. Herd, Peru; Alternate Councilor, Dr. Russell Lavengood, Marion; Necrologist, Dr. E. B. Jewell, Logansport, re-elected.

The next meeting will be September 20, at Huntington.

E. R. Clarke, M.D., *Councilor*

TWELFTH COUNCILOR DISTRICT

The Twelfth Councilor District is making a fight against socialized medicine.

The attendance was very good at the Twelfth District meeting which was held in Fort Wayne on April 4, 1950. A Scientific Program was given in the afternoon. The 7 o'clock dinner for the doctors and their wives was followed by a talk by Dr. James L. Doenges, Anderson. Subject: "The Doctor As a Community Leader." A discussion followed.

In attendance at the District meeting were Dr. C. S. Black, President I.S.M.A.; Dr. J. William Wright, Indianapolis; Ray E Smith, Executive Secretary I.S.M.A.; James A. Waggener, Field Secretary I.S.M.A.; R. S. Saylor, Executive Vice-President Mutual Medical Insurance, Inc., and Mrs. Truman E. Caylor, President state Woman's Auxiliary.

Officers elected for the next year were: Dr. Arthur R. Savage, President; Dr. William J. Gerding, Vice-President; Dr. Edward H. Schlegel, Secretary-Treasurer; and Dr. Myron L. Habegger of Berne, as Alternate Councilor.

M. B. Catlett, M.D., *Councilor*

THIRTEENTH COUNCILOR DISTRICT

The Thirteenth annual District meeting was held in South Bend on November 9, 1949. The meeting consisted of a morning session at the South Bend Medical Foundation, during which papers on the usefulness of the Papanicolaou test in the early diagnosis of carcinoma of the cervix and the treatment of preinvasive and invasive carcinoma of the cervix were given. The afternoon session began with a business meeting which was called to order by the president, Dr. D. L. Urschel of Mentone. It was voted to hold the next year's meeting at Michigan City. The officers for the year 1950 who were elected are: Dr. Louis E. How, South Bend, President; Dr. Daniel D. Stiver, South Bend, Vice-President; Dr. O. E. Wilson, Elkhart, Secretary-Treasurer; Dr. Kenneth L. Olson, South Bend, Councilor, to fill out the unexpired term of Dr. A. E. Ellison, the President-Elect of the Indiana State Medical Association; Dr. G. O. Larson, LaPorte, Alternate Councilor. Doctor Ellison has been Councilor for the thirteenth district for 12 years and served this District and the Council of the State Medical Association very capably during this time.

A scientific program followed the business session in the afternoon. The program was as follows: 1. "Early Diagnosis and Treatment of Carcinoma of the Lung," by Paul H. Holinger, M.D., University of Illinois College of Medicine. 2. "Bulbar Poliomyelitis," by T. C. Galloway, M.D., Evanston Hospital, Evanston, Illinois. 3. "The Differential Diagnosis of Jaundice," by E. A. Marshall, M.D., City Hospital, Cleveland, Ohio.

In the evening a dinner was held and the speaker of the evening was Associate Professor B. A. Waldman, who gave a paper entitled "The Medical Application of Nuclear Physics."

A new venture was begun at the time our District meeting was held and this was the organization of a district auxiliary. Mrs. R. B. Stout of Elkhart was elected president and Mrs. Armstrong of Michigan City was elected secretary.

During the year we made a survey in regard to the wishes of the members about having postgraduate courses sponsored by the State Medical Association. About one-fourth of the members answered the questionnaire and of this group 74 percent were in favor of having the courses.

The various county societies in the District have been actively working against socialized medicine and the chiropractic attempt to lower the standards of the medical license laws of the state of Indiana. Speakers have been supplied to various lay organizations where possible.

Emergency service is being worked out for the most suitable methods of each community. New contracts with the welfare boards are being set up in various counties. The doctors in the District are becoming more active civically and can thus help direct the various health projects such as cancer, tuberculosis, polio, et cetera. The state and national legislators have been contacted by personal talks, letters, and telegrams at various times during the year.

Our membership in the Thirteenth District has slightly increased over a year ago. Generally the affairs of each county society are in good condition and the societies are active.

Kenneth L. Olson, M.D., *Councilor*

EXECUTIVE COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Meeting nine times during the period of August 1, 1949, to August 1, 1950, the Executive Committee has handled a large volume of administrative business. In order not to trespass upon the duties of the Council, matters which could be postponed were referred to the Council.

Few, if any, of the Executive Committee meetings have been completed under five hours, and in some instances the large amount of business has kept the committee in session six or seven hours. Thoughtful consideration and discussion have been given to all problems before decisions were reached. The members of the committee are deeply conscious of their responsibilities, and have given generously of their time and talents in administering the affairs of the association.

A recital of the Executive Committee's actions will not be repeated inasmuch as minutes of all meetings have appeared in THE JOURNAL prior to the annual convention. For the benefit of the Reference Committee, however, copies of the printed minutes are attached to this report.

The year marked three changes in the personnel of the committee. Dr. Carl H. McCaskey, of Indianapolis, after serving for fourteen years on the committee, the last three years of which he was chairman, retired January 1, and Dr. Walter L. Portteus, of Franklin, was elected chairman. The committee feels it sustained a deep loss in Doctor McCaskey's retirement, and misses his helpful advice and counsel. Dr. C. J. Clark, of Indianapolis, was elected by the Council to succeed Doctor McCaskey. A change in the by-laws last September made the treasurer a member of the committee. We have profited from having Dr. A. F. Weyerbacher, of Indianapolis, the treasurer, as a committee member.

THE JOURNAL

Charged with the financial management of THE JOURNAL, the Executive Committee is proud to report that progress has been made in reducing production costs—for the first time in five years. A new contract with C. E. Pauley & Co., printers, was negotiated for the year 1950 last December. Under the new agreement, we are able to produce a 96-page issue of THE JOURNAL for approximately $200 less than in 1949.

An additional savings of $75 a month has been effected by switching to a lighter coated paper stock. This change took place in March, and we doubt if any of the readers were able to notice the difference.

Our committee takes pride in pointing to a saving of $2,024.69 in JOURNAL printing costs for the first six months of 1950 in comparison with the first half of 1949. In addition to the savings in printing and paper stock, a contributing factor was the printing of a total of forty less pages in the six issues.

Total JOURNAL printing costs for the last five years follow:

Year	Cost	Number of Pages (Inserts Excluded)
1945	$12,042.36	1,288
1946	$21,283.49	1,476
1947	$24,790.34	1,462
1948	$26,391.00	1,380
1949	$28,572.41	1,360
1950 (6 months)	$10,634.13	564

The following table shows the number of JOURNAL pages for the past six years:

Year	Reading	Per Cent Reading	Adv. Pages	Per Cent Adv.	Total Pages	Avg. Pages Per Issue
1944	758	56	588	44	1346	112.1
1945	580	44	754	56	1334	111.1
1946	696	46	824	54	1520	126.7
1947	681	45	837	55	1518	126.5
1948	703	49	707	51	1410	117.5
1949	740	53	652	47	1564*	262.0

* Includes 172 pages of "One Hundred Years of Indiana Medicine."

Advertising

THE JOURNAL is carrying slightly less advertising this year than it did in 1949. It is hoped that by the end of 1950 the income from this source will be about the same as the 1949 calendar year. Four hundred letters soliciting advertising for the Medical Year Book Number (July, 1950) were mailed in May, and $508.50 worth of business was realized. This was $53.50 less than from the same activity a year ago.

A comparison of advertising revenue for the first six months of the last three years with a like period for 1950, follows:

First Six Months	1947	1948	1949	1950
From A.M.A. agency	$ 9,779.78	$ 8,743.76	$ 8,133.26	$ 7,836.86
Direct to JOURNAL	5,167.11	5,066.43	4,564.23	4,467.31
Total	$14,946.89	$13,810.19	$12,697.49	$12,304.17

Special Numbers

Five issues of THE JOURNAL were devoted to special subjects during the last year. They were: General Practice, August, 1949; Centennial Convention, September, 1949; Cancer, April, 1950; Conservation of Vision, May, 1950; and Medical Year Book (roster number), July 1950.

MEDICAL DEFENSE ACTIVITIES

1. **Malpractice cases.** A year ago, at the time of this report, August 1, 1949, the following nine cases were pending before the committee, four of which were closed during the year, leaving five cases still pending:

Case No. 200—Suit filed February 12, 1932. Pending.

Case No. 249—Suit filed January 6, 1944. Pending on change of venue. Because of death of defendant, case probably will be dismissed when court convenes in September.

Case No. 251—Suit filed September 25, 1942. Pending.

Case No. 252—(Closed.) Suit filed August, 1944. Dismissed for lack of prosecution.

Case No. 255—Suit filed September, 1945. Awaiting assignment for trial.

Case No. 256—(Closed). Suit filed February 27, 1946. Case settled, with judgment entered for defendant. Expense, $458.23, paid July 26, 1950.

Case No. 264—(Closed). Filed January 28, 1948. Case contested on the pleadings and terminated on rulings of the court on demurrers.

Case No. 266—(Closed). Filed March 17, 1948. Case contested on the pleadings and terminated on rulings of the court on demurrers.

Case No. 268—Suit filed September 7, 1948. Pending.

Since August 1, 1949, and up to August 1, 1950, the following five new cases have come before the committee, making a total of nine cases pending at the present time as against nine unclosed cases at the same time last year:

Case No. 269—Filed September 28, 1949. Pending.

Case No. 270—Filed September 28, 1949. Pending.

Case No. 271—Filed September 16, 1949. Pending on change of venue.

Case No. 272—Filed December 27, 1949. Pending.

Case No. 273—Suit not yet filed. Effort being made to obtain settlement.

2. Medical Defense Fund Statement, from August 1, 1949, to August 1, 1950:

Balance, August 1, 1949		$2,937.73
Receipts:		
Dues, 74—1949 members	$ 55.50	
3390—1950 members	4,237.50	
Interest on bonds	224.99	4,517.99
		$7,455.72
Disbursements:		
Malpractice fees	$ 458.23	
Salary of Association attorney	1,800.00	
Miscellaneous expense	500.00	2,758.23
Balance in Medical Defense Fund checking account, August 1, 1950		$4,697.49

W. L. Portteus, M.D., *Chairman.*
C. J. Clark, M.D.,
C. S. Black, M.D.,
Alfred Ellison, M.D.,
A. F. Weyerbacher, M.D.,
W. U. Kennedy, M.D.

COMMITTEE ON CONSTITUTION AND BY-LAWS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Two changes in the By-Laws of the Indiana State Medical Association were recommended by the Council within the past year. The Council directed this committee to prepare the necessary amendments for submission to the House of Delegates at the 1950 annual convention in French Lick.

Therefore, acting in accordance with the directive of the Council, we submit the following amendments to the By-Laws:

1. That Section 2 of Chapter I—Membership—be amended by the addition of the following: "Provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect."

2. That Section 12, Chapter XI—County Societies—be amended by addition of the following: "In the event the county society remits a member's dues for good cause, and the secretary of a county medical society recommends in writing the remission of the state association dues of said member of the society, and shows good cause why such recommendation should be granted, the Council shall have the power to remit such dues."

The aforementioned suggested changes in the By-Laws are all that were received by this committee.

Ray Elledge, M.D., *Chairman,*
Walter F. Kelly, M.D.,
Gordon A. Thomas, M.D.,
I. C. Barclay, M.D.,
Charles F. Overpeck, M.D.

COMMITTEE ON INDUSTRIAL HEALTH

House of Delegates,
Indiana State Medical Association.

Gentlemen:

This committee has had two meetings during the year. The first meeting was on September 27, 1949, and problems relative to maximum weight-lifting by women, employability of handicapped individuals, and the development of a handbook for medical personnel in industry were discussed. A subcommittee was appointed to explore this last point further.

On December 1, 1949, a joint meeting was held with the members of the State Industrial Board. Mr. Maurice T. Harrell, chairman of the board, explained the various problems that the board had relative to the medical phase in the administration

of the workmens compensation laws. As a result of this meeting, this committee volunteered the whole-hearted cooperation of the association in helping the board with the various medical problems.

This committee brought this problem to the attention of the Executive Committee of the association. The Executive Committee then prepared a statement of policy and pledged cooperation of all the member physicians in compensation cases. This policy was published in THE JOURNAL, February, 1950, page 124. To insure statewide coverage this committee then sent a letter to each physician in the state advising him of this action and asking for his cooperation.

The Industrial Board was very pleased with this action and commended the committee for this prompt cooperation.

E. S. JONES, M.D., *Chairman*,
F. M. WHISLER, M.D.,
H. D. CAYLOR, M.D.,
L. W. SPOLYAR, M.D.,
R. C. SWAN, M.D.,
B. K. WESTFALL, M.D.,
H. W. GARTON, M.D.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Committee on Medical Education and Hospitals has considered many phases of postgraduate medical education and submits the following observations:

(1) The rapidity with which new methods are developed in medicine and the desire of the profession for this information necessitates constant and continuous revision of postgraduate educational procedures.

(2) The postgraduate programs are needed in the smaller county societies. Here are the general practitioners who may not have adequate professional relief that they may take time for postgraduate work, and they often have difficulty in finding time for keeping abreast of current literature.

(3) The effectiveness of postgraduate education varies with the method of presentation and the ability of the instructor to keep the audience interested. Case presentations and the use of visual aids rate as the most effective means of teaching, with panel discussions which stimulate audience participation next. Experience seems to show that didactic lectures are least popular.

(4) Any extensive program in our state will result in overworking our best teachers.

(5) Telephone extension programs from medical centers offer a solution for the postgraduate medical education problem. This method as now developed includes previous detail work whereby visual aids may be correlated with the voice of the distant lecturer by loud speaker. This plan when properly developed promises to be a method equal in value to television as a method of postgraduate instruction. It enables the busy doctor to obtain current medical knowledge without having to leave his community.

(6) The well-organized hospital staff is capable of offering the best in postgraduate education. The contact gained by staff membership carries with it every educational advantage. For this reason, every doctor permitted to practice in a hospital should be a member of its staff.

(7) Emergency telephone consultation service between physicians is of great advantage in certain situations, but it should not be considered an adequate substitute where careful study and considered judgment is required.

(8) Since postgraduate medical education is so dynamic and limitless, the services of a full-time man, who thoroughly understands the problems of private practice, is essential to a successful program in our state.

HARRY E. KLEPINGER, M.D., *Chairman*
HARRY P. ROSS, M.D.,
HERMAN M. BAKER, M.D.,
CLEON A. NAFE, M.D.,
DONALD J. CASELEY, M.D.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

A year of busy activity upon the part of the Committee on Public Policy and Legislation was climaxed on July 10 when the President's Reorganization Plan No. 27 was overwhelmingly rejected by the United States House of Representatives. The House action was, in fact, a test vote on "socialized medicine." Eight of Indiana's eleven representatives, four Republicans (one paired) and four Democrats, voted against the Plan. The vote indicates that the eight representatives . . . always with their ears to the ground . . . were convinced that the people did not want a new department of Health, Education and Security headed by Oscar R. Ewing, America's No. 1 champion of socialized medicine.

A similar Reorganization Plan was defeated in the Senate in 1949, both of Indiana's U. S. Senators voting against it.

Throughout the year your committee has been constantly bombarding our Senators and Repre-

sentatives in Washington with letters and telegrams about federal legislation, almost all of which met with our disapproval. Pressure was exerted against including physicians in the Social Security Act (they were excluded) and for removal of the permanent and total disability section in the act to extend social security coverage (which was done). Certain parts of the School Health Bill were opposed successfully, as well as a number of other bills which were deemed socialistic and against the best interest of the people.

More than a dozen bulletins on various angles of legislation were mailed to legislative committees and/or secretaries of county medical societies. Items on legislation were inserted in I.S.M.A. News Flashes so that every member of the association received the information.

Sixty-nine of the eighty-two county medical societies in the state have reported the appointment of legislative committees. This is a very important county committee, for through it much can be done on influencing legislation from the grass-roots level. Our committee wishes to acknowledge the great amount of work done by the county societies and to encourage them to continue until the forces of socialism are driven out of government.

The committee, on April 20, mailed to every member an envelope containing the pamphlet, "Sit Back, Doctor, and Let George Do It," also a booklet on "How Candidates for Congress Stand on the Issue of Government-Controlled Medical Services," and the voting record of the members of the 1949 Indiana General Assembly on the chiropractic bill.

Two members of the committee, accompanied by the association's attorney and executive secretary, appeared before the Platform Advisory Committee of the Indiana Democratic party to ask for planks in the 1950 party platform against socialized medicine and the lowering of educational standards for practitioners of healing. The association's position on the two issues were submitted in writing to the Republican Platform Committee. The health planks of each party were printed in the August JOURNAL, and the committee, while not getting everything it wanted, felt that its efforts were rewarded.

Looking to the 1951 session of the Indiana General Assembly, it is hoped that the three physicians who are candidates for the House of Representatives will be elected. Dr. Walter F. Kelly is a holdover Senator and will help hold the lines in the so-called "upper body." The old fight to keep chiropractors from getting their own licensing board so they can escape the present educational requirements is expected. Fifty thousand copies of a pamphlet, "The Doctor's License: What It Means to You," explaining the Indiana law for licensing of healing practitioners were distributed.

The work of the committee has been closely aligned with that of the Indiana A.M.A. Campaign Coordinating Committee and the Committee on Public Relations. It has been a pleasure to cooperate with these two groups in fighting for proper health legislation.

The committee has cooperated with the leadership of the American Medical Association in legislative policies. The executive secretary has been extremely helpful.

J. WILLIAM WRIGHT, M.D.,
DON E. WOOD, M.D., *Co-chairmen*,
JOHN M. PARIS, M.D.,
NORMAN R. BOOHER, M.D.,
WILL THOMPSON, M.D.,
J. R. DOTY, M.D.,
J. S. NIBLICK, M.D.,
CHRIS W. CULLNANE, M.D.,
HAROLD J. HALLECK, M.D.,
JAMES L. WYATT, M.D.,
HOWARD ALLEN, M.D.,
GEORGE R. DANIELS, M.D.

COMMITTEE ON PUBLIC RELATIONS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The public relations of a state medical association is not confined to the work of any one committee. Public relations is the day-by-day activity of each physician in his professional and public contacts, and the programs of nearly every other committee.

The budget of the Committee on Public Relations does not in itself provide funds for a comprehensive public relations program. The committee continued issuance of "I.S.M.A. News Flashes," believing the news letter to be good intra-professional public relations. "Flashes" is a medium for supplying physicians with information of a semi-confidential nature, of encouraging better physician-patient relations and of informing the members about activities of the association. A large share of the committee's appropriation has gone into producing and mailing the monthly letter.

The committee, mostly through its chairman, has lent its support to other committees whose work has been in the sphere of public relations. Two examples are the Committee on Public Policy and Legislation and the Indiana A.M.A. Campaign Coordinating Committee. On March 12, 1950, the Committee on Public Relations joined with the two aforenamed committees in sponsoring a conference in Indianapolis for representatives of county medical societies, at which time the plan for opposing socialized medicine was outlined.

The Subcommittee on Grievances of the Committee on Public Relations, which was created by the House of Delegates last September, has been an

active agency of the parent committee. It is making a separate report on its stewardship.

The Committee on Public Relations desired to hold a state-wide conference of newspaper editors and radio executives, such as has been done in some other states, but time and budget did not permit. It is recommended that the 1950-51 committee give serious study to the advisability of holding such a meeting in Indianapolis in the near future.

EARL W. MERICLE, M.D., *Chairman,*
W. D. GATCH, M.D.,
B. E. EDWARDS, M.D.,
DAVID R. JOHNS, M.D.,
JOSEPH B. DAVIS, M.D.,
JAMES W. DENNY, M.D.,
GEORGE W. WILLISON, M.D.

SUB-COMMITTEE ON GRIEVANCES

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Forty written complaints have been received during the first half of 1950. Thirty-three of these have been disposed of and seven are still under consideration. Fifteen of the complainants were critical of alleged excessive fees for medical and hospital services, five complained of difficulty in securing the services of a physician. The remaining twenty covered a wide range of accusations against doctors.

As was expected, a few of the letters were ill-tempered and disclosed the writers as unlikely to be satisfied with any reasonable settlement of their troubles. We were pleased to find that most of the complainants and most of the doctors concerned were very cooperative, and a majority of the misunderstandings have been adjusted promptly and satisfactorily.

The establishment of this committee received much favorable comment from the press and the public at large. We believe it has been good public relations.

The number of cases presented has been too small to support any valid conclusions as to the value of this committee to the state medical association, but we think that some of the results of our efforts were very well worth-while. We believe the committee should be continued.

The job has entailed a large volume of correspondence which has been done by the headquarters staff. To them we wish to express our sincere thanks.

J. T. OLIPHANT, M.D., *Chairman*
CHARLES N. COMBS, M.D.
GEORGE R. DANIELS, M.D.
C. H. MCCASKEY, M.D.
AUGUSTUS P. HAUSS, M.D.

COMMITTEE ON PUBLICITY

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your committee has met regularly in the headquarters office twenty times during the past year for the purpose of handling all newspaper releases, radio and television programs.

The usual "Hints on Health" releases for use in some 150 newspapers throughout Indiana have been continued, as has the 15 minute radio program over Indianapolis station WFBM. In addition, your committee has instituted a series of television programs over the same station. Several special news releases have been prepared for release to Indiana papers throughout the year.

"Hints On Health"

The work of the committee in preparing the "Hints on Health" Column is a routine matter, but is considered important. We feel it necessary that the public receive accurate and proper information on medical subjects. With this thought in mind, the following articles have been released through the "Hints on Health" column:

Watch the Heat	Saving Eyesight
Century of Progress	Spreading Germs
Physical Therapy	Your Child's Hearing
Heartburn	Pilonidal Cyst
Scurvy	Tularemia
Mechanical Backache	Hemorrhage
The Human Brain	Shock
Viruses	Chew Food Well
Leg Ache	Yellow Jaundice
The Gallbladder	Spring Hay Fever
Psoriasis	Spring Exercise
Pulmonary Tuberculosis	Length of Life
Your Heart	Care of Feet
Arthritis	Hard of Hearing
Measles	Poison Ivy
Infantile Eczema	Swimming Safely
The Prescription	Tuberculosis
The Hair	Appendicitis
The Knee Joint	Summer Camp
Deformities	Undulant Fever
Superfluous Hair	Glaucoma
The Menopause	Take a Vacation
The Common Cold	Night Driving
Intestinal Flu	

General News Releases:

The following general news releases were sent to all newspapers in the state during the year:

Twenty-four Hour Medical Service

Uncle Sam May Pay Doctor's Bills—But He Will Use Your Tax Money

1949 State Meeting

Awarding of Medical and Nursing School Scholarships

I.S.M.A. Exhibit at Indiana State Fair

Physicians to Receive 50 Year Awards
Diabetes Detection Week
Surgery with Poisoned Arrows
Nine General Releases about the State Convention
Historic and Scientific Exhibits at State Convention
A.M.A. Clinical Session
Doctors Suggest Resolutions for Keeping Healthy
Medical Profession Organizes Committee to Hear Grievances
Doctors Pledge Cooperation in Speeding Industrial Cases
Annual Conference of County Medical Society Officers
Medicine in the Next 50 Years.

Radio Programs

Radio station WFBM has continued to carry the weekly transcribed series procured from the A.M.A. Bureau of Health Education. The subjects of the programs used were:

The Story Behind the Discovery
The Public Comes First
Melody of Life
The Living Proof
Fair and Cooler

Television Programs

The association was offered the use of the television facilities of station WFBM for presenting programs through this new medium. The first such program was used on December 30, 1949, and since then several films have been cleared for use. However, due to the almost impossible task of securing permission for use of films from the various producers, the programs have not appeared with any degree of regularity. Your committee has urged the A.M.A. to prepare materials for use over television and was informed in June that the Board of Trustees had appropriated $10,000 for use in preparing materials for this purpose. We are hopeful that in the very near future films and materials will be available in such quantities that our program may appear with some regularity.

Miscellaneous

The committee has cooperated with other committees of the association in assisting in every way possible to make the educational campaign and public relations program effective. The committee purchased, for distribution to all physicians, four thousand reprints of the October 11 issue of Look Magazine, which carried a pictorial story of the A.M.A. and its many functions.

The Committee on Publicity would appreciate, at all times, suggestions from the profession for strengthening the usefulness of the medical profession before the public of our state.

MARLOW W. MANION, M.D., *Chairman,*
JAMES O. RITCHEY, M.D.,
HOMER G. HAMER, M.D.,
FRANK B. RAMSEY, M.D.

AUDITING COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Auditing Committee held its annual meeting on August 2, 1950, at the Indiana National Bank, Indianapolis. Investments of the association were examined and found to be in order in both the General Fund and the Medical Defense Fund. A detailed list of bonds held by the association, totaling $41,000.00 in the General Fund and $15,000.00 in the Medical Defense Fund, is contained in the treasurer's report on pages 887, 888 and 889.

Cash balances in the Indiana National Bank, the American National Bank, the Fletcher Trust Company, and the Bankers Trust Company, as shown by the July 31, 1950, bank statements, also were examined. These accounts consist of the General Headquarters Office Fund, the Medical Defense Fund, THE JOURNAL Fund, and the Petty Cash Fund, respectively, and show the following balances as of July 31, 1950:

General Fund	$54,891.35
Medical Defense Fund	5,305.72
THE JOURNAL Fund	15,035.68
Petty Cash Fund	13,236.71
	$88,469.46

O. B. NORMAN, M.D., *Chairman,*
CLAUDE DOLLENS, M.D.
ERNEST H. PRICE, M.D.

COMMITTEE ON CANCER

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Committee on Cancer met January 29, 1950, in the Claypool Hotel, Indianapolis. Committee members present were: Drs. Chester A. Stayton, Russell Malcolm, Mell B. Welborn, and Paul J. Bronson. Guests were: Drs. C. S. Black, John VanNuys, Lall G. Montgomery, Thurman B. Rice, Leroy Burney, Wendell C. Anderson, Edwin A. Lawrence and Mr. Rollis Weesner.

President Black expressed confidence in the ability of his Committee on Cancer to deal adequately with the problems coming before it and praised the progress being made in this field.

Dr. Edwin A. Lawrence, newly appointed oncologist to the faculty of the Medical School, was introduced to the committee. Doctor Lawrence was assured that appointment of an oncologist had been desired for some time and that he would receive support from the physicians of Indiana and from the Indiana Cancer Society.

A review of cancer control activities by the Indiana Cancer Society during the past year was presented by Mr. Weesner, Executive Director.

This included the Cancer Society's public education program, professional education, the development of services, cancer detection, diagnostic clinics and research activities. He revealed that approximately $100,000 had been spent in service activities in 79 of the 92 counties in Indiana and that 19 new projects had been instituted this year. He also stated that more than $100,000 had been invested in research and professional education by the Society, Indiana Elks Association, and Lions Clubs. This does not include approximately $150,000 from the American Cancer Society, Damon Runyon Fund and National Cancer Institute. These research projects are now in operation at Indiana University, Purdue University and Notre Dame University, with the greatest concentration in Indiana University and the Medical Center.

The question was raised whether or not the education of the public might be proceeding too fast compared to professional education regarding the disease of cancer. The general opinion of the committee was that relatively the public education program was ahead of the professional program and that professional education should have greater emphasis. Dean VanNuys of the Medical School told the committee that added funds are available from the National Cancer Institute to increase the teaching program and application had been made for funds to construct further research and clinical facilities at the Medical Center. Your chairman can now report that teaching funds in the amount of $29,400 were granted to the Medical and Dental Center and that $126,000 has been earmarked for Indiana University Medical Center, to be supplied at such time as the University can produce $173,000 for the erection of facilities which would be known as Indiana University Cancer Institute.

Your committee considered a suggestion from Dr. Leroy Burney relative to the development of cytological services which could include training in the Papanicolaou technique and others, as well as some nursing and follow-up service in the field of cancer by the State Board of Health. He suggested these activities be closely related to the Medical School. Your committee pointed out that the function of the Medical School is to teach and recommended the Board of Health should work with and through the Medical School, thus using funds most effectively and efficiently. It was also recommended a cytological teaching program should not be hurried and that it was undesirable, at least at present, for technicians to attempt reading Papanicolaou slides. The committee asked Drs. Burney and Lall G. Montgomery to work out a program and resolution relative to such services that could be submitted to the committee, Board of Health and Medical School.

Dr. Wendell C. Anderson, Director, Division of Gerontology and Chronic Diseases, State Board of Health, reported that eight regional cancer institutes for nurses had been held in various parts of the state at which several of our members participated.

He also reported that the "Cancer Bulletin" would continue to be sent to all doctors in Indiana, and hereafter would include an Indiana page. His report on the growth and present status of the Indiana Tumor Registry was:

> To January 1, 1950, there had been 3,721 reports and 4,603 slides submitted, 67 hospitals represented and 18 pathologists had held 11 meetings during the year, at which 513 cases were studied. This material has been the basis for two seminars conducted at Billings Veterans Hospital, which attracted pathologists from the entire country. A resolution of commendation and support to the Indiana Tumor Registry was unanimously approved.

Your committee issued warnings in THE JOURNAL to members of the Association relative to questionable advertising of the "Iodoacetate Test for Cancer" by the American Reagents Company of Philadelphia.

Your Committee a'so approved the revised method of selecting directors to the Indiana Cancer Society, whereby one lay and one medical director will be chosen from each of 13 districts throughout the state, with four ex-officio members and ten elected at large.

The "information centers" established by the Cancer Society and their effective work in cancer education and services is approved and gratifying to your committee.

The recent change in policy of the American Cancer Society relative to the value of cancer detection clinics had considerable discussion. These clinics have proven not to be the answer to early detection of cancer. Your committee agrees with the newer policy of the national society that *"every physician's office should be a cancer detection center."*

Your committee further restates its hope that diagnostic clinics in established hospitals throughout the state might be further developed and points out that in addition to improved diagnostic services there are excellent educational opportunities for physicians through use of such clinics.

Although the American College of Surgeons lists only six diagnostic cancer clinics in Indiana, the committee was advised that twenty centers are now organized for diagnostic services. Your committee expressed hope that more of these centers will seek certification by the American College of Surgeons. Your committee recommends that consideration by the medical profession in the state through its association should be given to the further promotion of general physical check-ups.

We are cognizant of the fact that while cancer detection clinics have been extremely wasteful when only cancer was looked for that such clinics have

demonstrated the extreme value of periodical physical check-ups for general good health. Such a program might be developed upon the slogan, "Every doctor's office a physical check-up center." Community education and cooperation by county medical societies could be of extreme value, not only in finding early cancer but in comprehensive medical care, including preventative, early diagnostic and curative services.

CHESTER A. STAYTON, SR., M.D., *Chairman,*
DAVID D. TODD, M.D.,
MELL B. WELBORN, M.D.,
PAUL J. BRONSON, M.D.,
RUSSELL MALCOLM, M.D.

COMMITTEE ON CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

A very successful conference of officers of Indiana's eighty-two county medical society officers was held at the Claypool Hotel in Indianapolis on Sunday, January 29, 1950. The attendance was 157.

The feature address of the conference was delivered by Russell I. Richardson, Lebanon attorney, who discussed British socialism as he observed it on a thirty-day "look-see" visit in England.

Other conference speakers discussed subjects of current interest to the officers. They included Dr. Walter L. Portteus, Dr. Byron N. Lingeman, Ray E. Smith, Dr. Earl W. Mericle, Dr. C. S. Black, Dr. Walter F. Kelly, Dr. James L. Doenges, Anson Thomas, Dr. Cleon A. Nafe, James A. Waggener, and Thomas A. Hendricks of Chicago. Ample time was provided on the program for discussion of the talks.

Dr. A. M. Mitchell was reelected chairman at the business session.

A. M. MITCHELL, M.D., *Chairman,*
FRANK W. MESSER, M.D.
DAVIS W. ELLIS, M.D.
ROBERT K. WEBSTER, M.D.
ERNEST R. BEAVER, M.D.
DONALD G. STURGIS, M.D.

COMMITTEE ON CONSERVATION OF VISION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

This committee held a breakfast meeting during the 1949 convention of the Indiana State Medical Association. The guest speaker was Dr. William L. Benedict of the Mayo Clinic.

The committee also prepared papers for the Conservation of Vision issue of THE JOURNAL, May, 1950.

This comprises the activities of this committee during the present fiscal year.

RICHARD P. GOOD, M.D., *Chairman*
CARL RUDOLPH, M.D.
D. HAMILTON ROW, M.D.
KENNETH L. SHAFFER, M.D.
ROBERT SMITH, M.D.

COMMITTEE ON CRIPPLED CHILDREN SERVICES

House of Delegates,
Indiana State Medical Association.

Gentlemen:

A meeting was held at St. Vincent's Hospital, Indianapolis, on March 26, 1950, on call of Dr. Wayne R. Glock, chairman.

Members of the committee present were:
Stanley Casey, M.D., Huntington
Carl D. Martz, M.D., Indianapolis
J. Neill Garber, M.D., Indianapolis
Joseph C. Lawrence, M.D., Evansville
Wayne R. Glock, M.D., Fort Wayne
Invited guests were:

George J. Garceau, M.D., Indianapolis, representing Indiana University Medical Center Orthopedic Services;

Robert B. Acker, M.D., South Bend, representing The Northern Indiana Hospital for Crippled Children at South Bend;

Fred W. Brown, M.D., of Fort Wayne, and Mr. Carl King, representing the Department of Public Welfare;

Mr. Robert Branson, representing the National Foundation for Infantile Paralysis;

Mr. Patton, representing the Indiana Society for Crippled Children;

Mr. Ort Walter, representing the Vocational Rehabilitation Division;

Mrs. Edith Lindley, representing the Department of Public Welfare;

Mr. Ray Smith, Executive Secretary, Indiana State Medical Association.

A two-hour discussion was held and a survey of the activities of all the above represented agencies caring for Crippled Children was heard. Each organization presented its functions and activity for the past year and their current operation. No definite action or recommendations were made at this meeting.

Another meeting was held in the executive office of the Indiana State Medical Association, Hume Mansur Building, Indianapolis, on April 23, 1950.

Members of the committee present were:
Stanley Casey, M.D., Huntington

Carl D. Martz, M.D., Indianapolis
Wayne R. Glock, M.D., Fort Wayne
Joseph C. Lawrence, M.D., Evansville

The data acquired from the first meeting, March 26, 1950, was reviewed, and the committee wishes to remind the Indiana State Medical Association that in event of future polio epidemics that the State Department of Public Welfare will provide, at the request of the attending physician, both pediatric and orthopedic consultation service, and that further care will be determined by the patient's or patient's family's ability to pay. It is further urged that the term "Medical Indigency" be more clearly defined than heretofore and the physician should assume definite responsibility in this determination.

It is recommended that the State Department of Public Welfare, Services for Crippled Children, be restricted to care of indigent crippled children. We are opposed to the use of any facility of the Department of Public Welfare or of any other Governmental Agency by any private organization for the treatment of any crippled child, poliomyelitis included, who is not indigent, where adequate private facilities are available.

It is recommended that the Welfare Department cooperate in every way possible with the Technical Committee in Orthopedic Surgery of the Children's Bureau and that our committee should act as a similar Technical Advisory Committee to cooperate with the Indiana Polio Committee of the State Medical Society and with the Polio Committee of the Indiana State Board of Public Health, the Governor's Commission on Handicapped Children and the Department of Vocational Rehabilitation. Your committee feels that there are adequate facilities and adequate provision for the care of Crippled Children in the state of Indiana at the present time.

In our opinion, when patients have hospital and medical insurance coverage equal to or better than the Blue Cross-Blue Shield, they should be considered as nonindigents and not be eligible for Welfare Care.

The committee is aware of the need of an increase in the scope of services to Crippled Children and feels that careful study and increasing provision of care will be needed in the future. The problem of the Orthodontic Handicapped Child was brought to the attention of this committee, with the question whether this child should be taken care of through the Crippled Children's Service of the State Department of Welfare. It is the opinion of this committee that this problem should be referred to the Indiana State Dental Association.

Wayne R. Glock, M.D., *Chairman*,
Stanley M. Casey, M.D.,
Carl D. Martz, M.D.,
J. Neill Garber, M.D.,
Joseph C. Lawrence, M.D.

COMMITTEE ON DIABETES

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Diabetes of the Indiana State Medical Association has had one meeting. This meeting took place at the Columbia Club in Indianapolis on Sunday, November 11, 1949, at 11 A.M. All members of the committee were present. The results of the Detection Program of last year were discussed and plans for the 1950 Detection Drive were made. Soon after this meeting a questionnaire was sent out to all county societies in the state, of which about 50 percent returned a reply. Certain valuable information was obtained, including the fact that Indiana's Detection Drive netted 41,684 urines examined, of which 680 were found as new diabetics. It is encouraging to note that the Detection Drive acted as a stimulus in many communities for the continuance of the detection program as a community service, increasing undoubtedly the total number of urines examined and therefore the total new diabetics discovered. After the first of the year, a revised brochure was sent out by the Diabetes Committee to each county medical society giving detailed suggestions concerning the organization of a Diabetes Detection Program. Diabetes Detection Week will this year be held during the week of November 12-18. The Committee on Diabetes sincerely appreciates the cooperation it received during last year's drive and hopes for even greater cooperation from the county medical societies this year in making this year's program eclipse that of 1949.

Marshall I. Hewitt, M.D., *Chairman*
B. M. Edlavitch, M.D.
William D. Gambill, M.D.
Laura Hare, M.D.
Lloyd Rosenbaum, M.D.

COMMITTEE ON HARD OF HEARING

House of Delegates,
Indiana State Medical Association.

Gentlemen:

(1) The committee recommends that the name of this committee be changed to be The Committee for the Conservation of Hearing.

(2) It is further recommended that this committee sponsor a luncheon at the annual meeting of the State Medical Association better to inform other members of the profession of the activities of this group.

(3) In order to implement those recommendations made one year ago by this Committee it is urged that an interchange of consultants be arranged between the Indiana Speech and Hearing Therapists' Association and the Ear, Nose and Throat Section of the Indiana State Medical Association, working in close relationship with the Indiana Academy of Ophthalmology and Otolaryngology. It is hoped that when these consultants are appointed that they will organize within their group to assist the Committee for the Conservation of Hearing in the preparation of any needed legislation or improvements of the rehabilitation programs for educational institutions as well as other agencies, governmental and private, interested in hearing conservation. Those governmental agencies interested in hearing conservation have met to discuss their mutual problems, and they are also working towards a cooperative program for good interrelationship between the members of the medical groups and all agencies and groups promoting hearing conservation and speech therapy.

(4) We further urge that all physicians become familiar with existing state laws providing for services for hearing handicapped children and children with other types of disorders which limit their educational adequacy. In 1941 a law was passed by the state Legislature which required audiometric examinations of every public school child, each year. Following these examinations those children who are found deficient are to be referred to their physician for necessary medical treatment. For those defective in hearing acuity and beyond the scope of ordinary medical measures, various phases of educational rehabilitation is to be provided, such as instruction in lip-reading, auditory training and/or hearing aids. This law was an obligatory, not a permissive law. Some communities have fulfilled the letter of the law but too many still ignore it.

(5) In 1947 additional legislation was passed which is designed to help the handicapped school child. This law is a supplement to a law passed in 1927. It provides that school corporations are empowered by permissive legislation to establish special education programs for hard-of-hearing, defective speaking, crippled and sight-loss children. The goal of this law is to enable children to eliminate disorders, whenever possible, which interfere with their education, or to learn compensatory procedures to make up for their deficiencies. The State Department of Education is empowered to pay up to 100 percent of the additional cost of this program to the public school system establishing such a program. The methods for the establishment of such a program are relatively simple, and there is little reason why any community in the state of Indiana should not furnish services which will help in the rehabilitation of its handicapped children. Those officials in each community should write the State Department of Special Education, sending the names of its handicapped children and a brief statement of the nature of each handicap, and request that they be enabled to start a program, with state approval. We feel that it is your obligation to see to it that the handicapped children in your communities get their full share of opportunities available under these laws: Acts 1941, Chapter 212, Page 642: Acts 1927, Chapter 211, Page 599: Acts 1947, Chapter 276, Page 1102.

Guy A. Owsley, M.D., *Chairman,*
George W. Seward, M.D.,
Dillon D. Geiger, M.D.,
Carroll O'Rourke, M.D.,
Samuel M. Baxter, M.D.

COMMITTEE ON HEART DISEASE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Heart Disease of the Indiana State Medical Association met on January 11, 1950, in the headquarters office, 1021 Hume Mansur Building, Indianapolis, Indiana. Members of the committee in attendance were A. N. Ferguson, M.D., Fort Wayne; Walter S. Fisher, M.D., Columbus; William M. Dugan, M.D., Indianapolis; and Stuart R. Combs, M.D., Terre Haute, Chairman. Guests in attendance were Dr. Leroy E. Burney and Dr. George M. Brother of the Indiana State Board of Health. A report was given of $47,000 in available Federal Funds to conduct a state heart program. This program was to include a symposium on heart disease and to employ the aid of a nutritionist if such a service might be needed in the work of the local heart societies. This program was given the unanimous approval of the committee and the symposium was held at the Indiana University Medical Center on Wednesday, February 15.

There being no further business, the meeting was adjourned.

Stuart R. Combs, M.D., *Chairman,*
A. N. Ferguson, M.D.,
George M. Cook, M.D.,
Walter S. Fisher, M.D.,
William M. Dugan, M.D.

INDIANA A.M.A. CAMPAIGN COORDINATING COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

It is one and one-half years since this Committee was named for the purpose of correlating the efforts of our association with those of the A.M.A. in an all-out effort to defeat compulsory health insurance. At that time the outlook for defeating such legislation seemed poor indeed. President Truman, Federal Security Administrator Oscar Ewing, and other prominent members of the party in power were strong advocates of such a program. The American Medical Association had begun a militant campaign to defeat the proposed legislation which would in fact socialize the medical profession.

This committee, since its inception, has cooperated fully with the American Medical Association in this campaign. In a report to this House of Delegates one year ago we stated, "This committee wishes to reemphasize that this task (defeating compulsory health insurance) is one in which every physician and the many friends of our way of life must play a part. This is a crusade against socialism and statism. It is an all-year-round campaign if the fight is to be won."

During this year the activities of this committee have been of four types:

Resolutions Opposing Compulsory Health Insurance

Last year we reported to you that we had forwarded 86 resolutions to the A.M.A. At the San Francisco meeting in June of this year, 10,206 resolutions were recorded from the United States. Indiana had secured 1,525 of these and led all states. West Virginia, in second place, had secured 778. This fine accomplishment is a tribute to the excellent cooperation of the Woman's Auxiliary and many physicians and friends of the medical profession throughout the state of Indiana.

Distribution of Pamphlets

It is estimated that at least 2,000,000 pamphlets, showing the evils of government medicine, have been distributed throughout Indiana during the past year. Many of these have been routed through the Medical Association headquarters, while many have been sent directly from the A.M.A. They have been distributed by physicians, druggists, hospitals, many business and other organizations. The purpose of this committee has been to stimulate this activity in every way. The voluntary plans for prepayment medical and hospital care have been most helpful in the distribution of literature on this subject.

Speakers Campaign

During the year we had the good fortune of obtaining Cecil Palmer of London, England, noted author, lecturer and publisher, who made seven appearances throughout the state addressing lay audiences on the subject of "British Socialism." Another outstanding speaker, Dr. Ralph J. Gampell, self-exiled physician from Manchester, England, made many appearances before groups ranging from 100 to 1,200 in Indiana. His services were secured through the offices of the National Education Campaign. Many of the speeches of these prominent speakers were broadcast by radio through the fine cooperation of radio stations in this state.

Numerous talks have been given through the efforts of local medical societies and the Woman's Auxiliary, using capable local speakers. When these or other organizations have requested a speaker, the state association has furnished them, using mostly capable public speakers, friends of the profession, but usually not physicians.

Newspaper Education Campaign

In April of this year your committee instituted a state-wide newspaper advertising program, for the purpose of informing the people of the dangers of compulsory health insurance legislation and the advantages of the present type of medical practice through voluntary health insurance. This campaign will be increased through September and October and end just prior to November 1st. This campaign has been designed to tell the public the truth about government medicine and make them conscious of their rights as citizens to decide this very vital controversy through the use of the ballot box and by expressing their views to their elected representatives in Washington.

It was originally planned to handle this campaign through our headquarters office, and send the copy to the individual physicians in each county to place in their local newspapers. As complications of the program and the problems of distribution developed, it became evident that the proper way to carry out this program was to secure a capable advertising agency to handle it for us. Accordingly, this committee interviewed some seventeen Indiana Advertising Agencies and Public Relations Firms. It was the unanimous opinion of the committee that we employ Keeling and Company, Indiana's largest advertising agency, to handle the preparation and placement of the entire campaign. Publishers in the state have been high in their praise of this campaign and most all of them have become doubly interested in the fight that the medical profession is putting forth to preserve for the American people our American way of life.

These are but a few of the things that have been accomplished in Indiana, but we feel that this is a brief summary of the most important items. This report would not be complete without paying tribute to the Woman's Auxiliary, to the many local medical societies throughout the state who have done their full share in this united effort, and to the many allied professions and other organ-

izations that have united with us in their determined effort to stay the progress of State Socialism. We have been in constant contact with many of these other groups and met with them on occasions to assist in their planning to cooperate in this effort.

It is difficult to appraise the results of all of these efforts. Naturally, it would seem that the united effort directed by the A.M.A. has been very effective. All newspaper reports seem to agree that National Compulsory Health Insurance is a dead issue during this session of Congress. The defeat of President Truman's Reorganization Plan No. 27 was considered a test of the sentiment for or against socialized medicine. The rejection of this resolution by an unexpectedly large vote certainly should be heartening to the medical profession and to our many friends.

In Indiana the campaign has certainly had its effect. In reading the booklet, "Guidepost for Voters," distributed in the spring by us to our members, you had the opportunity to read first hand the views of the folks back home as expressed by resolutions and by their personal letters.

Your committee believes that the 1950 elections are very important to medicine. With this in mind, we encouraged the Woman's Auxiliary to assist the Legislative Committee in making sure that every Indiana physician and his family was qualified to vote and to make sure that they did vote. As a result of this effort, Indiana physicians throughout the state went to the polls almost 100 percent, and their vote was felt in many of the races during the primary. The fall elections are naturally of increased importance. Every physician in Indiana who values his freedom in the practice of medicine and as an indvidual, should see that every person he knows, including himself, casts his ballot for the right candidate. Our effort can be lost if we fail to make sure that only sincere Americans, whose first obligation is the preservation of freedom of the professions, business and of the individual, are elected to represent us in the halls of government. This is true at not only the national level, but also at the state level.

As we look ahead our problems are many, our fight is not won; while the main attack of our enemies has been slowed, many rear guard skirmishes are taking place. Efforts are being made to distract the profession from their fight, by a flood of propaganda designed to lull us into a state of complacency by thinking we have won our fight. At the same time we are reading this propaganda, more and more measures are being introduced into Congress, the provisions of which, if accumulated, will socialize the practice of medicine. For this reason, it behooves each of us to remain constantly alert and informed; we must continue to increase our efforts; we must retain the offensive while it is ours.

Unfortunately your committee feels that many of our societies have remained complacent with respect to this great battle medicine is fighting. If we are to win a decisive victory, we must rid ourselves of this spirit and adopt instead a militant attitude on this subject. Each of us is responsible, and if and when any individual society shirks its responsibility in this campaign, it serves only to weaken our position. It is, therefore, the hope of your committee, that while generally the physicians of Indiana have accomplished much, each and every one will roll up his sleeves and pitch in so that there cannot be the least element of doubt in the minds of the public and the politicians that socialized medicine has no place in our American way of life.

Your committee feels that two statements made by Dr. Elmer L. Henderson, as he accepted the office of President of the American Medical Association, are particularly pertinent in closing our report. He said, "I call upon every doctor in the United States, no matter how heavy the burdens of his practice may be, to dedicate himself, not only to the protection of the people's physical health, but also to the protection of our American way of life, which is the foundation of our economic health and our political freedom." His closing words were these, "With the help of God and the American People, the medical profession will continue to minister to the sick, to relieve human suffering, and to uphold the ideals which have made America the hope of freedom-loving people everywhere."

CLEON A. NAFE, M.D., *Chairman*
C. H. MCCASKEY, M.D.
WALTER L. PORTTEUS, M.D.
EARL W. MERICLE, M.D.
MRS. TRUMAN E. CAYLOR, *Chairman* A. M. A. Coordinating Committee, Woman's Auxiliary.

COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Indiana Inter-Professional Health Council has had no meeting during the past year.

E. H. CLAUSER, M.D., *Chairman,*
WILLIAM C. REED, M.D.,
C. S. BLACK, M.D., *Ex officio,*
W. U. KENNEDY, M.D.,
J. WILLIAM WRIGHT, M.D.

COMMITTEE ON INFANTILE PARALYSIS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The activities of the Committee on Infantile Paralysis of the Indiana State Medical Association have been carried out in conjunction with the Indiana Polio Planning Committee, with whom a joint meeting was held on February 14, 1950. Efforts have been continued to encourage the care of patients with poliomyelitis in the local hospitals, rather than transporting so many of them to the larger hospitals in Indianapolis. As a part of this effort, a subcommittee of the Polio Planning Committee has prepared an excellent authoritative booklet entitled "Recommendations on Nursing Procedures and Techniques in Hospitals Treating Poliomyelitis Cases." This booklet is to be distributed to hospitals, schools of nursing and other organizations likely to be interested. All physicians in Indiana are to receive a copy.

Educational conferences have been held, under the sponsorship of various organizations in many places throughout the year. Among these was a two week institute for nurses of supervisory capacity, held at the Riley Hospital in April.

On June 7, 1950, an all day symposium on poliomyelitis was conducted at the Medical School and was attended by over 100 physicians.

A need has been expressed, particularly by hospital administrators, for a concise summary of the services available to patients with poliomyelitis from the many agencies concerned with them in one way or another. This is now in preparation and will be sent to hospitals, county medical societies, welfare departments and public health nurses.

At the time of writing there is no indication of a major epidemic in Indiana this year, so that further activity of the committee will be necessary only if the situation changes.

Lyman T. Meiks, M.D., *Chairman*
Leroy E. Burney, M.D.
R. A. Craig, M.D.
Kenneth T. Knode, M.D.
Charles N. Manley, M.D.

COMMITTEE ON INSTRUCTIONAL COURSES

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Instructional Course Committee has had a number of meetings in the late spring and early summer of 1950 in the organization of a course of instructional classes, the schedule for which appears in The Journal for the months of July, August, and September.

This consists of a course of 30 topics, each to be discussed for a period of one hour. Permission of The Council of the state association for the inclusion of the names of the instructors to give the courses was secured and, for the first time, these names are printed on the schedule.

There is every reason to feel that the Instructional Course program scheduled for 1950 will be equal in quality to any of the successful courses given in the past.

Gordon W. Batman, M.D.,
Russell A. Sage, M.D., *Co-Chairmen,*
James Wagoner, M.D.,
J. T. Oswalt, M.D.,
John D. Van Nuys, M.D.,
J. Lawrence Sims, M.D.,
E. Paul Tischer, M.D.,
Floyd T. Romberger, Jr., M.D.

COMMITTEE ON MATERNAL AND CHILD HEALTH

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Since the last report was submitted the Committee on Maternal and Child Health has met twice; once during the last annual meeting, and again on April 19, 1950. Various matters have been discussed by the committee at its meetings; several definite proposals were made and certain continuing activities have been carried on directly by members of the committee or concurrently with others in the interim.

The Indiana Study of Child Health Services, as done by the American Academy of Pediatrics in cooperation with the Indiana State Board of Health, was presented for approval to the Maternal and Child Health Committee. The committee approved of the distribution of the booklet to the medical profession, dental profession, and other interested state organizations. Doctor Carlo and Doctor Jewett were given the responsibility for further distribution of the report.

Earlier recommendations, emanating from the committee and approved by the Council of the State Medical Association, for the establishment of a premature care training center at the Indiana University Medical Center, were taken up by the committee. Doctor Meiks reported that efforts were still being made to formulate plans for such a training center. He stated that it would take much time to develop facilities and get personnel.

Upon the recommendation and through the personal efforts of Doctor Eggers, a premature care training institute was conducted for the hospitals and physicians in Lake County on April 26 and 27. This institute was carried out with the assistance

of teaching personnel of the Indiana State Board of Health. Doctor Meiks and Doctor Huber played an active part in this educational program. The program was considered a success and it was recommended that similar programs be developed in other areas of the state.

Upon a request made by the committee, the matter of air conditioning in hospital maternity and nursery services was investigated by the School of Public Health of Indiana University Medical School. The report indicated that the knowledge of air conditioning in hospital services was still in the research stage and that the committee should make no recommendations until further work had been done by scientific research agencies.

Final approval of a Criteria for the Classification of Live Births was held up pending the final adoption of such a criteria by the International Committee of the World Health Organization.

Diet pamphlets for the nutritional guidance of mothers and children were presented for approval to the committee. These pamphlets will be prepared by the Indiana State Board of Health and made available to practicing physicians and nurses. They are simple in form and intended as guides understandable to lay persons.

The establishment of an Indiana Council for Children and Youth, approved by the committee and recommended by the Indiana Study of Child Health Services, was realized by action of the Governor taken on November 18, 1949. This committee, composed of some 90 members representing all agencies and groups with interests in services for children, convened on February 17 and again on June 9, 1950. Prominent members of the Indiana State Medical Association, including members of the Committee on Maternal and Child Health, are participating in the activities of this very important coordinating council.

At the April meeting of the committee, proposed legislation, sponsored by the CIO, was presented for the approval of the committee. This legislation proposed support to a bill to provide medical and hospital care for school children to cover injuries occurring in the course of school activities. The committee resolved that with the limited information at hand and doubt as to the necessity for such legislation, it would withhold approval of any such legislative action at this time.

Activities of the individual members will continue individually and by correspondence, and there will be a called meeting of the committee before the fall meeting of the State Medical Association.

Neal E. Baxter, M.D., *Chairman*,
E. R. Carlo, M.D.,
Robert E. Jewett, M.D.,
G. W. Gustafson, M.D.,
Rex W. Dixon, M.D.,
C. O. McCormick, Sr., M.D.,
H. W. Eggers, M.D.,
Carl P. Huber, M.D.,
Lyman T. Meiks, M.D.

COMMITTEE ON MEDICAL AND NURSING SCHOOL SCHOLARSHIPS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Council in 1947 appropriated $3,000 a year to finance six scholarships for medical school students, and $1,200 a year to provide scholarships for six girls studying nursing. The medical school scholarships pay $500 a year, while the girls in nursing schools receive $200 annually.

A student who accepts a medical scholarship agrees to practice for a period of five years in some Indiana community in need of the services of a physician upon the completion of his internship, or to repay the money plus interest of 4 percent. The object of these scholarships is to increase the supply of doctors in the rural areas.

The purpose of the scholarships for student nurses is to enable young women without sufficient funds to become nurses and thereby add to the supply of nurses.

The committee expected to place its first scholarship recipient in some rural community this past summer, but the young doctor elected to repay the money supplied him. He was a junior at the time the scholarship was awarded him. Two young men now on internships will be available for placement in the summer of 1951. Scholarships today are held by two freshmen, one sophomore, one junior and two seniors.

Through funds provided by the widow of a physician, a scholarship paying $200 annually to a medical student is administered by the committee. The committee invites contributions from other philanthropic individuals who would like to help some deserving young man or woman receive a medical education, and, incidentally, help some country town solve its medical services problem.

Four young women who won nursing scholarships in 1947 were graduated this year, and the scholarships held by them have been assigned to girls entering freshmen classes this fall. Two senior students hold the other scholarships. One of the girls wrote the committee in June, as follows:

> "School is over for the year and graduation was held yesterday. We received our first stripe last Friday, making us the new senior class. It was indeed a thrill putting on and wearing the new stripe. The thrill is still present, but along with it is the responsibility that goes with being a senior student.
>
> "My goal has almost reached its attainment. In another year I shall be a graduate nurse. I would never have been able to achieve it without the aid given me by the Indiana State Medical Association.

"My prayers and thanks will never suffice the gratitude present in my heart. Thank you from the bottom of my heart."

The committee administers scholarships for five other girls in nurse training. Funds for four of the scholarships were provided by Mr. and Mrs. H. C. Krannert, New Augusta, Indiana. The Krannerts have indicated they would continue the scholarships, with some variation. Two girls holding "Krannert scholarships" were graduated this year.

Money contributed by Mr. Joseph E. Meyer, Indiana Botonic Gardens, Hammond, Indiana, is helping another girl, who is a senior.

Our committee feels that the two scholarship projects, costing the association $4,200 a year, are sound investments and pay liberal dividends in public relations.

C. J. Clark, M.D., *Chairman*,
James M. Kirtley, M.D.,
James L. Lamey, M.D.,
Ex-officio:
C. S. Black, M.D.,
W. U. Kennedy, M.D.,
J. William Wright, M.D.,
Donald E. Wood, M.D.

COMMITTEE ON MENTAL HEALTH

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Mental Health had two meetings during the year and a number of informal discussions among the members at various times.

At its first meeting on November 7, 1949, the committee adopted a resolution to alert each county medical society to the growing importance of the Indiana Mental Hygiene Society. The authority of the Council of the ISMA for circularizing the county societies was asked and this was granted. Accordingly, each county society received a mimeographed letter urging it to assume some degree of cooperative responsibility for the mental hygiene movement, as well as to offer assistance in the establishment of new chapters of the Mental Hygiene Society. It was suggested that each county society might find it expedient to appoint or elect a liaison officer or committee to work with those groups interested in mental hygiene. This form letter, sent to each county society, was well received by some of the societies.

In its meeting on November 9 your committee also discussed the charge which had been made by various persons that in some localities in the state pressure from local political quarters added to the difficulties of state institutions in obtaining efficient organizations of personnel. Your committee resolved that local annoyances of political and personal nature would appear to be inconsistent with the general policies of the ISMA and that the committee should on suitable occasion permit this opinion to become known so as to strengthen the professional policy of the Indiana Council for Mental Health and to lend the greatest assistance to those administering the state institutions. An occasion for disclosing this opinion arose on November 9 at a meeting of the Indiana Neuropsychiatric Association when your chairman was requested to present a report as chairman of the committee of that organization for study of "Common Goals in Public Psychiatry."

The meeting on November 9 of the Indiana Neuropsychiatric Association was important, in that the Hon. Governor Henry Schricker was a guest along with representatives of the Indiana Council for Mental Health and the Indiana Mental Hygiene Society. Governor Schricker clarified some points in the problem of administering state institutions and gave hearty assurance that the aim of his administration would continue to be the furtherance of a comprehensive program for better care of the mentally ill.

The final meeting of the committee was held on July 15, 1950. In connection with the committee's program of stimulating the interest of county societies in the mental hygiene movement, note was taken of the establishment of the eighth county Mental Hygiene Society. It was reported by a member of the Board of Directors of the Mental Hygiene Society that each of its local chapters had accepted and received cooperation from the corresponding county medical society. Your committee resolved that the recommendation be carried to all the delegates that this guidance of organized medicine in mental hygiene activities be fostered and continued.

The committee also resolved to call attention of the House of Delegates to the fact that the first annual meeting of the Indiana Mental Hygiene Society was held in Indianapolis on April 27, 1950. A psychiatrist of international reputation was guest speaker and Governor Schricker again voiced his strong personal interest in implementing the Larue D. Carter Memorial Hospital and other state institutions for the best possible psychiatric service.

Your committee by resolution recommended that the Editor of the Indiana State Medical Association Journal be alerted to the fact that its advertising columns had been opened to some institutions for the treatment of alcoholism and drug addiction when those same institutions are currently advertising in the public lay press. It was resolved that no advertising should be accepted by the state Journal from such institutions as also appeal to the lay public by way of newspapers. It was further resolved that the committee recommend that no advertisements be accepted from private institutions having to do with psychiatric treatment

unless they have qualified by achieving licensure by the Indiana Council for Mental Health or other recognized licensing agency. The committee further advised that the published standards for such institutions adopted by the A.M.A. be made minimum standards for institutions advertising in the state JOURNAL.

By resolution your committee approved of the policies of activities of the Indiana Council for Mental Health and particularly of its Deputy Director.

Your committee gave extended consideration to the movement for expanding and/or improving facilities for psychiatric care in general hospitals. By resolution, this goal was approved in principle, subject to the special circumstances prevailing in each institution.

E. VERNON HAHN, M.D., *Chairman*,
A. M. DEARMOND, M.D.
LOUIS W. NIE, M.D.,
CLIFFORD L. WILLIAMS, M.D.,
ALBERT J. CREVELLO, M.D.

COMMITTEE ON NECROLOGY

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Due to a lapse in the committee last year no report was published. This year the committee has prepared a report covering both 1948 and 1949 which was published in the July issue of THE JOURNAL.

JAMES B. MAPLE, M.D., *Chairman*,
E. B. JEWELL, M.D.,
W. D. INLOW, M.D.

COMMITTEE ON PREPAID MEDICAL AND HOSPITAL INSURANCE

House of Delegates,
Indiana State Medical Association

Gentlemen:

The Committee on Prepaid Medical and Hospital Insurance met at Indianapolis, March 19, 1950, with the following members present: Drs. Bruce Stocking, Muncie; A. F. Weyerbacher, Indianapolis; Virgil McCarty, Princeton; Lee Maris, Attica; and Augustus P. Hauss, New Albany, chairman. Mr. Ray E. Smith, executive secretary, Indiana State Medical Association, and Mr. R. S. Saylor, executive vice-president, Mutual Medical Insurance, Inc., also attended the meeting and presented factual information and ably assisted the committee.

Doctor Weyerbacher, committee member and treasurer of Mutual Medical Service, Inc., presented a detailed report on the financial condition and progress of "Blue Shield."

Mr. Saylor presented the proposed changes in the Master Fee Schedule of Blue Shield, showing many increases in fees for medical services. The committee considered each item and approved the schedule as actuarilly sound, and a fair charge for medical and surgical services to patients in the lower income groups.

Doctor Stocking reported that Blue Cross was giving serious consideration to asking Blue Shield to include anesthesia in its contract. This brought on a discussion of the encroachment of the hospitals on the private practice of medicine. The committee's opinion on this subject is included in our specific recommendations to the House of Delegates.

The executive secretary presented a letter received at the headquarters office suggesting that the Indiana State Medical Association promote and endorse all voluntary health insurance. It is the committee's opinion that not all companies operating in Indiana offer satisfactory contracts and that some may not be actuarilly sound. It would be imprudent for the medical association to single out particular companies for endorsement.

The committee discussed the progress and management of Mutual Medical Service, Inc. (Blue Shield), the doctors' company organized and sponsored by the Indiana State Medical Association. It commends the phenomenal membership growth and splendid financial condition, but believes that the Board of Directors should take a more active part in the management of the company.

The committee held a very lengthy discussion on the relationship of physician and patient in prepaid medical care.

(1) It was pointed out that much dissatisfaction and criticism of prepaid medical insurance could be avoided by the physician advising the patient in advance as to the estimated amount of fee and explaining to the patient that he was partially or totally covered by his insurance.

(2) It was pointed out that the basic fee schedule of Blue Shield was submitted to all county medical societies for approval and was a composite expression of what the physicians of Indiana considered fair compensation for services to patients in the lower income groups.

(3) It was pointed out that a few physicians and surgeons in various counties were charging far above the average, were disregarding the approved Blue Shield fee schedule in

low income cases, thereby jeopardizing the success of voluntary prepaid medical insurance and the preservation of the practice of medicine in the American way.

(4) It was pointed out that these were things that could be corrected by the individual physicians or regulated by each county medical society.

As a result of the foregoing discussions, the Committee on Prepaid Hospital and Medical Care respectfully requests the House of Delegates to approve the following recommendations and officially present them to the Board of Directors of Mutual Medical Service, Inc., and to the membership of the Indiana State Medical Association.

1. That anesthesia and other professional services rendered by physicians in the hospitals and now included in the Blue Cross contract be transferred to the Blue Shield contract as direct compensation to the physician for medical service.

These changes in contract to be made as rapidly as is feasible and considered actuarilly sound.

2. That the Board of Directors of Mutual Medical Service, Inc., amend its by-laws (if necessary) to provide regular and more frequent meetings of the board.

3. That in the interest of better physician-patient relationship, the extension of volunteer prepaid medical and hospital insurance, and the preservation of the practice of medicine in the American way, the House of Delegates of the Indiana State Medical Association go on record as:

(a) Favoring the physician advising the patient the amount of fee and its relation to insurance coverage;

(b) Encouraging physicians and surgeons to follow the Blue Shield fee schedule in low income cases;

(c) Frowning on exorbitant fees, endeavoring to establish a fair and more uniform schedule of fees throughout the state;

(d) Urging the medical profession to avert public criticism and possible government control by regulating itself and placing its own house in order.

AUGUSTUS P. HAUSS, M.D., *Chairman*,
I. C. BARCLAY, M.D.,
BRUCE STOCKING, M.D.,
A. F. WEYERBACHER, M.D.,
VIRGIL MCCARTY, M.D.,
LEE MARIS, M.D.,
WILLIAM A. KARSELL, M.D.

COMMITTEE ON RURAL HEALTH

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Committee on Rural Health has, for the past several years, been engaged in a limited program. While the program has been limited in scope, we feel that we have accomplished some worth-while results in developing a better understanding between lay people and the medical profession.

Our greatest accomplishment in this field was made possible through the two rural health conferences held during 1949. In these conferences we were successful in bringing together representatives of the medical profession, voluntary health agencies, public school officials, and farm people, for an open, frank discussion of health problems facing the people in rural communities. As a result, we believe many were shown how selfhelp and mutual cooperation could bring about a solution to many of their problems.

Since the present committee was appointed by Doctor Black, we have had many discussions as to methods we might employ to make the work of the committee more effective and thereby contribute more to the advancement of understanding between the medical profession and others. We feel that much can be done to produce a more workable organization in this field, that will in time become an influential vehicle for the public relations activities of the medical association and at the same time provide a means of developing constructive community programs that should have the enthusiastic support of the profession as well as other groups.

Your committee chairman attended the National Rural Health Conference in Kansas City in February. Here, at a meeting called by the A.M.A. Rural Health Committee, much emphasis was placed on the value and importance of state medical associations further developing rural cooperation through their respective committees and for an implementation of an active and aggressive program in the fields of rural and community health.

In March the committee sent the field secretary to Michigan to make a one-day study of the program being carried out in that state. It is with this background that we respectfully submit the following proposal for enlarging the scope of this committee. We seek your counsel and advice in this matter and desire to have your recommendations and your approval for beginning immediately to carry out the program as proposed. The decision to make the following report was made at the meeting of the committee on Sunday, March 19, 1950.

1. The committee feels that it, with the cooperation of the entire Indiana State Medical Association, should attempt immediately to organize at

the state level a group to be known as "The Indiana Health Improvement Foundation," or some similar name.

2. It is proposed that the membership in the foundation be opened to all bona fide agencies on the state level who are interested in health, including those who are devoting their entire time to the advancement of the health of our people. It is also felt that other organizations whose programs might include community or group health improvement should also be included.

3. It is proposed that the voting membership be composed of only those agencies who are willing to make a monetary contribution to the work of the foundation.

4. It is proposed that the organization structure be similar to that of the Indiana State Medical Association. The officers shall consist of a president, vice-president, secretary and treasurer. That the board of trustees, similar to our House of Delegates, be composed of representatives of the contributing organizations, and the executive committee shall then be elected from the board of trustees.

5. The amount of contribution shall be left open as to maximum and minimum. Any reasonable contribution to the activities of the foundation will entitle the contributing group to its voting membership.

6. The distribution of votes shall be limited to one each for the organizations contributing. The amount of contribution and representation on the board shall not affect this allocation of voting power.

7. Voting membership shall be open to all groups such as those enumerated in paragraph two.

8. There also shall be established an "associate membership." This classification shall include those organizations and agencies, both public and private, who are not so constructed as to permit their making a financial contribution. Associate membership shall also include a representative from the component county health councils that are established or that might be established in the future.

9. It is proposed that the associate membership shall constitute an advisory group to the foundation, but without voting power.

10. Honorary memberships shall be established for individuals not officially representing any organization, but who are individually interested in the advancement and improvement of health. Honorary members will not have voting power.

It was evidenced in the National Rural Health Conference that there is a ground-swell of interest developing for a full-scale and active program of this type. It is with the sincere belief that today there is a definite trend of thinking and growing determination on the part of the rural people to "Do the Job Themselves—Right in Their Own Community," rather than seek government help, that your committee solicits your approval for the development of an aggressive, full-scale program to encourage this thinking, and to develop a service arm that can help the people do the job themselves.

PROPOSED PROGRAM FOR SUCH AN ORGANIZATION

1. The proposed program for such an organization has no limit to its possibilities, but we list just a few of the major projects which such an organization might undertake in the beginning.

2. Expansion of membership; to encourage and solicit as soon as possible membership of all health organizations.

3. Further developing the activities of presently established county health councils.

4. Development of county units of the state level organization.

5. Planning and conducting a state-wide rural health conference.

6. Serve as a clearing house on health questions.

7. The development of a health bulletin.

8. Health film booking information service.

9. Assistance in planning and programming for county health councils.

10. Development of handbook of information; this to contain a directory of all health organizations operating in Indiana. This to define each organization and to explain the organization's program and services.

11. Establishment of health information centers throughout the state of Indiana.

12. Planning and conducting regional meetings of representatives of community or county health councils.

SERVICE

As the basic fundamental for the organization of such a foundation is to provide a means of offering the service of organized medicine in developing and consulting on community health problems, it is our intention that this organization concern itself with providing the necessary service to communities throughout the state in surveying their problems and counseling with them to find ways and means of solving their problems at the community level through local initiative.

It is difficult to place intangibles on paper, although many times these intangibles are the most valuable factors in a successful operation. Our concept of such an organization is that it would in a very short time earn for the medical profession and those interested in the organization the position of leadership in health matters, both at the state and local levels.

As the program develops and it becomes recognized, it is our considered judgment that the

medical profession and members of the foundation will be increasingly solicited to assume new roles of leadership, thus assuring guidance of a constructive nature in community health activities.

We further feel that such an organization could repeatedly and with success emphasize the necessity of communities recognizing the responsibilities which are rightfully theirs for the health of the people in their own areas. If successful in this accomplishment, a strong movement will have been set in motion which will deny the necessity for federal domination of health activities.

The foundation would constantly promote projects, both at the state and local level, designed to better the health of the people. This stimulation and guidance which will be developed as the organization is set in motion will develop better community health projects through individuals and community initiative.

By assuming and taking the initiative in the organization of health groups on the state and local levels, the medical profession has a means of avoiding the danger of questionable elements usurping this important function.

By making machinery available to improve conditions on a voluntary basis, the medical profession will be taking another step in avoiding the compulsory type of intervention in community matters. This should be especially true in the health insurance field. Further, by the fact that the association takes the initiative in establishing such an organization, as future problems arise positive action can be taken without the enervating and costly delay occasioned by the absence of such an organization.

It might be sufficient to say that such an organization would offer an opportunity for the medical profession and other interested groups to become identified harmoniously with the people's health activities and interests with mutual benefit and understanding.

You will, of course, appreciate the fact that many of the goals that may be attained by such an organization and many of the benefits that might be derived through such an organization are at this time mere thoughts. It is, however, our sincere judgment that such an organization would develop into a very beneficial means to further the influence of medicine to all people of our state, through a program of mutual understanding and cooperation, in frankly discussing each other's problems and promoting sound medical practices and working together to solve our problems and better the inequalities without the necessity of federal intervention and dictates.

As a matter of additional information on the above, this proposal was submitted to both the Executive Committee and the Council, who approved the plan in principle. Following this action, the committee called an all-day meeting in Indianapolis, at which time persons representing other organizations were invited to participate in the discussion of the proposal. This meeting, held on Sunday, April 30, 1950, was attended by the following, in addition to the committee:

F. S. Crockett, M.D., Chairman Rural Health Committee of A.M.A.
John D. VanNuys, M.D., Dean, Indiana University School of Medicine
Leroy E. Burney, M.D., Secretary Indiana State Board of Health
Donal H. Draper, D.D.S., Indiana State Dental Association
M. K. Hine, D.D.S., Dean, Indiana University Dental School
J. B. H. Martin, Indiana State Hospital Association
Mrs. J. A. Gillaspy, President, Association of Home Economics Clubs
Mrs. Nellie Flynn, Indiana Farm Bureau
Leroy E. Hoffman, Purdue University
Professor Harold E. Smith, Purdue University
Mr. Malcolm Mason, Purdue University
Mrs. Eva Gobbell, Purdue University

This group was enthusiastic with the program as outlined and each expressed his assurance that his respective organization would cooperate in making the proposal a workable plan. The group also went on record as approving the plan as outlined in principle and the chairman was asked to appoint a committee to make further study of the plan, discuss it with other organizations and to recommend ways of financing the activities of such an organization. The committee named the following persons to study the plan and report their findings in the near future: Donal H. Draper, D.D.S., Mrs. Nellie Flynn, Mrs. J. A. Gillaspy, Leroy E. Burney, M.D., J. B. H. Martin and L. W. Vore, M.D.

Your committee held a state-wide rural health conference at Purdue University in August. The conference, held in conjunction with the annual summer agricultural conference of the University drew a record attendance of approximately 1,000. Participants in the program were: Malcolm Mason, Frank G. Sink, M.D., John D. VanNuys, M.D., M. K. Hine, D.D.S., Miss Jeane Schockley, R.N., L. E. Burney, M.D.

Participating on the lay program were: L. E. Hoffman, Associate Director of Agricultural Extension Service, Purdue University; Mrs. P. C. Womacke, Social and Educational Director, First District, Farm Bureau; Mrs. Frank Hickman, Home Economics Clubs; Mr. Arman Shake, Knox County Health Committee; Mrs. J. W. Walker, President Indiana Congress PTA, and Mr. Frank Peck, Chicago, Managing Director Farm Foundation.

The evening program opened with an entertainment program followed by remarks by the following: Frank C. Hockema, Vice-President Purdue University; F. S. Crockett, M.D., Chairman Rural Health Committee of the A.M.A.; Mr. Larry Bran-

don, Secretary-Treasurer, Indiana Farm Bureau, Inc., Claude S. Black, President Indiana State Medical Association. The main address was given by the Honorable Henry F. Schricker, Governor of Indiana. Entertainment was furnished by the Lafayette Chapter of the SPEBQSA.

Throughout the day a mobile x-ray unit furnished by the State Board of Health was available for taking free chest x-rays of those attending the conference. The Indiana Tuberculosis Association cooperated in the x-ray program by assuming the expense of having the films read.

The committee desires the House of Delegates to review the proposed program of the committee and to grant its permission to the committee for immediately setting in motion the machinery necessary to place the plan in operation.

Frank G. Sink, M.D., *Chairman*,
Margaret Bassett, M.D.,
Dan L. Urschel, M.D.,
L. W. Vore, M.D.,
H. N. Smith, M.D.,
William E. Schoolfield, M.D.,
Louis E. How, M.D.

COMMITTEE ON SCHOOL HEALTH AND PHYSICAL EDUCATION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Committee on School Health and Physical Education has just completed a very active year. Meeting once a month, the committee has been favored with a large attendance of representatives from agencies interested in the problems that come before this committee. Invitations were issued and were accepted to participate in our discussions by: John D. VanNuys, M.D., dean of the Indiana University School of Medicine; M. K. Hine, D.D.S., dean of the Indiana University School of Dentistry; E. E. Ewbank, D.D.S., Secretary to the Indiana State Dental Association; Willard K. Patty, dean of the School of Physical Education, Indiana University; L. E. Burney, M.D., Indiana State Board of Health; Mr. Maurice Hunt, Indiana Industrial Board; Mr. Herbert Lamb, Department of Public Instruction; Miss Ethel Jacobs, director, Division of Public Health Nursing, State Board of Health; Mrs. D. E. Lybrook, president, Woman's Auxiliary to the Indiana State Medical Association; Frank G. Sink, M.D., chairman of the Committee on Rural Health of the Indiana State Medical Association; Mr. Robert Wyatt, executive secretary of Indiana Teachers Federation; Mrs. Nellie Flynn, chairman of the Woman's Division Indiana Farm Bureau and Mrs. Cecilia Shuck, Nutrition Department, Purdue University.

School Health Conferences

During the year your committee continued the school health conferences that have proved so popular among school officials. Five conferences have been conducted in the state, through the cooperation of Evansville College, Evansville; Hanover College at Madison; Franklin College, Franklin; and Ball State College at Muncie; as well as Indiana State Teachers College at Terre Haute. These conferences were well attended, and much cooperation has been given the committee by the Department of Public Instruction and the Board of Health of the state in conducting these sessions.

Committee Findings and Actions

Our various committee discussions have dealt with "How the teaching of health might be made more effective in our schools and how health services in the schools might be improved."

We have found that a shortage of adequately trained personnel (nurses, dentists, dental hygienists, health teachers) is one of the most serious bottlenecks in properly teaching health in the schools, and health program. Today, most schools are utilizing the services of athletic coaches and others trained in only a limited field of health, for teaching the broad subject of health. To fortify our position in this matter, the School of Health and Physical Education of Indiana University is conducting a survey of the schools of Indiana to determine the qualifications of those teaching health, subjects taught and methods of teaching. We expect this report to furnish a basis for establishing a plan to develop a more uniform program and teaching technique, as well as to prove the need for better trained personnel to teach this important subject.

In this respect, your committee adopted a resolution addressed to the Department of Public Instruction, State of Indiana, in which a request was made for the establishment of a special license for the teaching of "Health." We understand that this action has been favorably received and is at present undergoing study that may result in such a licensing classification being established by the state.

We believe that there should be a speed-up in the consolidation of small and inefficient schools in the interest of providing our children with a better quality and broader program of education.

Your committee has discussed and recommended that a study be made by the Nutrition Department of Purdue University to determine if the teaching of nutrition in the schools might not be improved. This department has promised its complete cooperation in this effort.

It has been called to the attention of the committee by the agencies cooperating with us in our program that many times it is difficult to know with whom they should work at the county medical

society level. Many times a county society will have several committees working in the field of community and school health problems. Your committee felt that the efficiency of our programs in these fields could be increased, if county medical societies would name one over-all committee to be responsible for all community and school health projects. This, we feel, would afford agencies a contact that would be informed at all times on all other health projects of the community, and would, therefore, be in a position to coordinate these projects. Also, it is our feeling that this would simplify the county society program and serve to keep them better informed on all projects concerning health being conducted in their respective communities. With this in mind, the committee adopted a resolution requesting the establishment of such a committee at the county society level and transmitted copies of the resolution to the county society secretaries. Also requested that each county society devote at least one program a year to a panel discussion of school health.

Another program that your committee feels needs considerable study and attention is that of providing medical service for school children. Programs in operation now vary in many degrees and in many counties, the school health program, in many communities, is almost devoid of any professional consultation and assistance. This problem is now being studied, and a survey is being made of the school examination programs being carried out in other states. In particular, we have been discussing the question of requesting state funds, such as is done in Pennsylvania, for the purpose of providing a thorough program of physical examinations of school children with adequate follow-up services. No definite action has been taken by your committee on this matter.

Your committee feels that the field of school health is of utmost importance to the medical profession, as our contacts and services rendered to school children gives us the opportunity to impress upon the minds of our future citizens and leaders the value of the present system of medical care. Through our school health programs, we are in a position to form opinions during the formative years of childhood and to establish a feeling of confidence that cannot be erased throughout their later years of life.

B. N. Lingeman, M.D., *Chairman*
Joseph H. Clevenger, M.D.
G. O. Larson, M.D.
Francis P. Jones, M.D.
Edith B. Schuman, M.D.
George V. Cring, M.D.
N. C. Isler, M.D.

COMMITTEE ON STATE FAIR

House of Delegates,
Indiana State Medical Association.

Gentlemen:

This report contains only the committee plans to date for the Indiana State Fair Exhibit, due to an attempt to meet The Journal July 15 deadline for this report.

The committee met June 4, 1950, at 3:00 p.m., in the state association office, to make arrangements for the exhibit for the Indiana State Fair, August 31 through September 8, 1950. The committee decisions were as follows:

First: Use the American Medical Association exhibit as a background for the booth.

Second: Have medical students take blood pressures of fair-goers.

Third: Ladies of the Auxiliary are to pass out campaign literature against the trend of socialized medicine.

Supplementary reports will be made before the House of Delegates at the French Lick meeting.

Malcolm O. Scamahorn, M.D., *Chairman*
Lowell F. Beggs, M.D.
Sam W. Campbell, M.D.
William D. Province, M.D.
Richard C. Pryor, M.D.

COMMITTEE ON TRAFFIC SAFETY

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your committee, after meeting with the director of the Traffic Safety Commission, state of Indiana, and discussing the commission's plans, wishes to go on record with the following recommendations:

1. We commend the present system of drivers' records established by the Indiana Bureau of Motor Vehicles and recommend a continuous and critical review of such records in order to reveal the intentional and deliberate violators who are the cause of the greatest percentage of fatal accidents. We further recommend that in accordance with the existing statutes, repeating offenders be cited before the chief hearing judge to show cause why their drivers' licenses should not be suspended or revoked, according to the merits of the case. It is further recommended that sufficient funds, necessary personnel, et cetera, be made available to make this record system work.

2. After listening to a report on the relation of speed to accidents, we recommend the establishing of an "absolute" speed law in Indiana, 60 miles per hour during the day

and 50 miles per hour at night, which will provide a uniform basis for decisions in courts throughout the state. We further recommend that training schools be set up, one day per week for 6 weeks, for justices of the peace, mayors, city judges and prosecutors, to attempt to secure uniformity of punishment for violations throughout the state.

3. Revision of the present law compelling doctors, under heavy penalty, to report all epileptics, as such, which violates the rights of privileged communication. Replacement of such law by one providing for the reporting of ANY "physical condition which renders the patient unfit for driving"; the exact diagnosis to be given only on demand and with permission of the patient.

4. Provide the Indiana State Police system with adequate personnel to administer and enforce the traffic laws and program, said increase to be accomplished as such personnel can be trained and absorbed efficiently.

5. We wish to commend the high school drivers training program, of class room instruction and behind-the-wheel experience, and recommend that this be extended and enlarged as quickly as it is efficiently possible over the state.

6. We do not condone the speeding of ambulances or private vehicles that carry patients, believing that more harm is done from such speeding than any over-all good.

7. We suggest some plan be worked out between state, city and county traffic enforcement personnel so that better and more efficient coordination be accomplished.

8. Believing that the manufacturers of automobiles could easily adopt many safety features which would help cut down the frightful toll of accidents and that such features would in no way decrease the efficiency or desirability of the vehicle, we wish to go on record as desiring such changes and suggesting the State Traffic Safety Commission and Council make our recommendations known to some of the manufacturers of automobiles.

This committee wishes to pledge to the Indiana Bureau of Motor Vehicles, the State Traffic Safety Commission and Council, and all other groups concerned, our continued assistance and cooperation in all possible ways to aid and extend this program for traffic safety.

G. T. Bowers, M.D., *Chairman*
Ralph C. Eades, M.D.
Gilbert D. Rhea, M.D.
Louis H. Osterman, M.D.
David Hadley, M.D.

COMMITTEE ON TUBERCULOSIS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Tuberculosis held a meeting on November 9, 1949, at the Hotel Lincoln in Indianapolis. The following recommendations were approved by the committee and submitted to the Council of the Indiana State Medical Association for their approval, rejection, or revision:

1. This committee believes that all organizations which promote any phase of tuberculosis work should express their emphatic opposition to any form of socialized medicine or compulsory health insurance. We understand the Indiana Hospital Association has made such a resolution and we think other organizations, such as the Indiana Tuberculosis Association, the State Board of Health, and the Indiana Chapter of the American Red Cross, should follow suit. It is also recommended that these state organizations encourage their national organizations to do likewise. (We would appreciate a copy of their resolutions.)

2. The committee thinks more study is advised concerning the number of available beds for the care of patients suffering from active tuberculosis, before any request is made for additional beds. We believe no new sanatoria should be built, but if needed, more beds can be added to present facilities. We commend the Indiana Council on Tuberculosis for beginning this investigation. We urge general hospitals to admit tuberculous patients (where isolation and bed rest is needed) until they can be transferred to specialized hospitals or sanatoria for treatment.

3. We advise that tuberculosis and health organizations request the State Legislature to make it mandatory that all food handlers, in grocery stores, restaurants, hotels, and drug stores, and dishwashers and bartenders, have a chest x-ray annually in order to work in such establishments. Furthermore, we advise that this routine x-ray be made a part of the drug store, hotel, tavern and restaurant's requirements for license—cost of the x-ray to be paid by either employee or employer, or both.

4. We request the State Legislature to pass a law that county commissioners are to allot sufficient funds to hospitalize cases of tuberculosis in any sanatorium in the state, in keeping with the policy of the state of Indiana, viz., the patient or relative of patient is obligated to pay part of the cost if financially able. The county commissioners should be required to hospitalize any active

case if requested to do so, especially the indigent.

5. The State Board of Health should be commended for its effort to quarantine recalcitrant cases of active tuberculosis in sanatoria and all other active cases who fail to obey precautions advocated by their physicians. We urge them to instruct all County and City Health Officers to enforce the law vigorously.

On January 15, 1950, the Council approved the entire list of recommendations and we submit them to the House of Delegates for consideration.

The Committee on Tuberculosis met at the Columbia Club in Indianapolis on Sunday noon, July 23. At this time the members approved two proposals submitted by Dr. Merle Bundy of the Indiana State Board of Health, namely:

1. Method of examination and follow-up of contacts of tuberculosis.
2. A suggested policy for disposition of specimens submitted to the laboratory for microscopic examination, culture, and guinea pig inoculation for tubercle bacilli.

At French Lick the committee will meet jointly with the County Tuberculosis Committees and members of the Indiana Chapter of the American College of Chest Physicians and any other physicians who may be interested, on Tuesday noon, September 26.

Paul D. Crimm, M.D., *Chairman*
Edward W. Custer, M.D.
Russell S. Henry, M.D.
O. T. Kidder, M.D.
L. A. Malone, M.D.
L. C. Marshall, M.D.
Robert A. Staff, M.D.
James H. Stygall, M.D.

COMMITTEE ON VENEREAL DISEASE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The objective of this committee is to encourage the utilization of the latest scientific knowledge regarding diagnosis and treatment of venereal diseases and to promote the application of the most effective epidemiological procedures for the control of venereal diseases. Because of the broad public health ramifications, in addition to the personal nature of these diseases, coordination of the activities of the public health agencies with those of the practicing physician is imperative for optimum effectiveness.

Your committee has therefore attempted to analyze the incidence and distribution of venereal diseases, re-evaluate diagnostic and treatment procedures in the light of rapidly developing and changing trends, consider the needs of the private physician in his contact with the problem and, finally, counsel the public health agencies in the performance of their programs.

At a meeting of the committee in Indianapolis on November 27, 1949, the problem of congenital syphilis was considered. It was pointed out that the occurrence of congenital syphilis today reflected a deficiency somewhere in the control program. With the requirement of the prenatal law of 1939 for serological test of all pregnant women, and with the availability of a most effective treatment (penicillin) to prevent congenital syphilis in the newborn, it was felt by the committee that there was an opportunity for improvement in this aspect of syphilis control. It was therefore decided to get factual data on the completeness of serological testing of pregnant women. Since report of this procedure is required on each birth certificate, the State Board of Health was asked to survey this item on the birth certificates of recent years.

During this meeting another point of interest was discussed. It was called to the committee's attention that since 1937 the State Board of Health has distributed various arsenical and bismuth drugs to physicians without charge for the treatment of syphilis in medically-indigent patients. Up until recent years these drugs had been used extensively by private physicians for the treatment of such patients. However, in view of the trend toward replacement of the heavy metals with penicillin for the treatment of syphilis, requests for penicillin were exceeding by far the requests for heavy metals. It was therefore decided by the committee to recommend to the State Board of Health that the State Board of Health consider the feasibility of adding penicillin to the list of antisyphilitic drugs available and to formulate a plan whereby the distribution of penicillin could be satisfactorily initiated.

At the conclusion of this meeting of the committee, there was a unanimous reaffirmation of the principle that industry should not be considered indigent and should pay for its own laboratory work, whether it be for pre-employment or other industrial purposes.

In follow-up of the proposals and recommendations made in the November 27 meeting, another meeting of the committee was held in Indianapolis on March 5, 1950. Dr. George M. Brother of the State Board of Health reported on the survey of birth certificates for the years 1947 and 1948. This material was presented in a graphic manner showing the completeness of reporting on a map with a county-by-county breakdown. A study of the 95,758 birth certificates for 1947 showed that 17,839, or 18.6 percent, indicated no blood test or failed to make a notation of blood test. In 1948 review of the 92,131 birth certificates showed that 10,270, or 11.1 percent indicated no blood test or failed to make a notation of the blood test. After

consideration of the information, the committee recommended that it be provided to the secretaries of all county medical societies with a request that attention of all physicians be called to the provisions of the prenatal law, and their cooperation in complying with its provisions be sought.

Doctor Brother then presented a plan for the distribution of penicillin without charge to physicians and venereal disease clinics for the treatment of syphilis in medically indigent patients. Doctor Brother requested from the committee some standard regarding treatment schedules by which the State Board of Health could be guided as to maximum amounts of penicillin which should be made available for a given case of syphilis. After very careful consideration by all members of the committee and definite qualification of the limitations of a single treatment schedule, the committee submitted the following suggested treatment schedule as one which would fulfill minimum acceptable requirements of all members of the committee and the great majority of syphilologists throughout the country for syphilis in pregnancy and early acquired syphilis:

> 600,000 units of procaine penicillin in oil with 2 percent aluminum monostearate given intramuscularly every day or every other day for 10 injections (total dosage of 6,000,000 units over a period of 10 to 20 days), with careful clinical and laboratory follow-up at frequent intervals, including at least one spinal fluid examination, over a period of two years.

In addition to the foregoing qualifications, it was specifically pointed out that this schedule was not to be construed as a universally adequate amount or a specifically indicated schedule in every case of syphilis. It was also agreed by the committee that additional necessary amounts of penicillin should be made available for cases with central nervous system syphilis.

Subsequent to the March 5 meeting, all of the forms for the initiation of this program for the distribution of penicillin and a concise statement of procedure was presented by Doctor Brother to the committee and was approved by all members of the committee. In addition to this, the plans for the distribution of penicillin were approved by the Executive Committee of the State Medical Association and the program was initiated on May 1, 1950. As was anticipated, the program was met by a favorable response from physicians throughout the state and has proceeded very satisfactorily. To date it has given every evidence of fulfilling the objectives for which the program was originally planned—early and adequate treatment of new syphilis infections.

In further follow-up of the March 5 meeting, a letter regarding the prenatal blood test law, a copy of the law, and a copy of the map showing the effectiveness of compliance with the provisions of the law by counties was sent to secretaries of all county medical societies. It is the feeling of the committee that this reminder to the practicing physicians in Indiana of their obligation to society for the better control of the tragedy of congenital syphilis is adequate to bring about unanimous compliance.

The committee takes this opportunity to commend all members of the association for their continued interest and support of a united program on this medico-social problem. The committee also commends the State Board of Health and expresses appreciation to the participating members of the staff for their splendid cooperation and untiring efforts to assist this committee in the mutual endeavor to bring about better control of this serious infectious disease.

Frank M. Gastineau, M.D., *Chairman*
Lucian A. Stamper, M.D.
Minor Miller, M.D.
James E. Engeler, M.D.
Samuel R. Mercer, M.D.

COMMITTEE ON VETERANS AFFAIRS AND REHABILITATION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The committee has kept liaison with the Council on National Emergency Medical Service of the American Medical Association with regard to the Civil Defense Program by having a member meet with the Council at their May meeting. Liaison has also been kept with the State Civil Defense program and the chairman of this committee has been named by the Governor as a member of the State Civil Defense Council.

Indiana University School of Medicine has sent Dr. John A. Campbell to a regional school for a week's indoctrination course in the medical care of atomic bomb casualties. The committee planned with the dean of Indiana University School of Medicine for a second phase indoctrination course of representative doctors invited from each county medical society in the state. This course will be given at the medical school this summer.

As a third phase, it is recommended that each county medical society have its representative who attended the course at Indianapolis transmit to his society the knowledge which he has secured, in order that each doctor in the state may have had an opportunity to learn the effects of an atomic bombing and the medical care of the casualties therefrom.

Medical Civil Defense plans have been worked on but not yet published, pending receipt of further information and an over-all plan from the National

Security Resources Board. We are advised a national plan for blood and blood plasma, which would be needed in tremendous quantities in the event of atomic bombing, will be issued by the National Security Resources Board by September 1, 1950. This may be a human blood bank plan, as suggested by this committee in 1948.

The committee recommends each county medical society appoint an Emergency Medical Service Committee to deal with matters governing medical education by the deferment of such students in the event of total mobilization, the staffing of hospitals, intra- and interstate medical assistance and the actual assignment and allocation of civilian physicians in the event of a national emergency requiring activation of a Civil Defense Program. Present directives from the National Security Resources Board indicate the responsibility for over-all planning of medical civil defense is the responsibility of state boards of health and recommend the coordination of local civil defense plans through county health officers.

At the Executive Committee meeting May 21, 1950, Doctor Black, as president of the state association, designated the members of this committee as the Emergency Medical Service Committee of the state association.

The fee schedule for medical services under the contract of the state medical association and the Veterans Administration was renewed for the fiscal year beginning July 1, 1950, and is the same as the fee schedule used in 1949 and originally published February 15, 1948, except for two amendments. These are the addition of blood typing and cross matching in combination, for which $3 is authorized, and a blood thiocyanate level determination fee of $2, which were requested by the committee. There is also an amendment to the contract made by the Veterans Administration, as follows:

Delete paragraph 5(c) reading as follows:

"It is further understood that services of physicians hereunder will be so utilized that fees therefor to any individual physician will not exceed $6,000 per annum without the prior approval of the Chief Medical Director, Veterans Administration, Washington, D. C. It will be the responsibility of the Veterans Administration to enforce this policy and to advise all participating physicians that it is in effect. All Veterans Administration Branch Medical Directors have been instructed with regard to this policy."

Include the following additional paragraph:

16. Except as otherwise specifically provided in this contract, all disputes concerning question of fact arising under this contract shall be decided by the contracting officer, subject to written appeal by the contractor within thirty (30) days to the head of the department concerned or his duly authorized representatives, whose decision shall be final and conclusive upon the parties hereto.

The committee attempted to insert an amendment which would authorize the payment to a general practitioner for multiple services to a veteran at a single office call or home call, so that it would not be necessary for the Regional VA Office to place a detailed report of circumstances on such bills before they could be paid. This amendment was denied. However, it will not affect the profession, since the Regional VA Office has issued directives to participating physicians as to the proper preparation of their bills and will add endorsements where necessary, so that prompt and proper payments will be made.

There have been no conflicts by the participating physicians and the Regional VA Office which have required consideration by this committee in the past year.

Glen W. Lee, M.D., *Chairman*
John M. Palm, M.D.
Charles F. Thompson, M.D.
Lester D. Bibler, M.D.
W. W. Holmes, M.D.

THE JOURNAL

House of Delegates,
Indiana State Medical Association.

Gentlemen:

In reporting to you concerning the publication of The Journal during the past twelve months, I would like to emphasize again, as on former occasions, the cooperation and deep personal interest which is and has been exhibited by all members of the staff.

During the year we have received an ample number of scientific papers. These have been reviewed by the Editorial Board and of those accepted as many have been published as our limited space permits. We now have an adequate, though not excessive, number of scientific contributions accepted and awaiting publication.

The format has been altered to include several new departments. "The Fourth Estate Looks at Medicine" is a page which is devoted each month to reprints of editorials from the public press which express the public's reactions to the activities of the profession. We have also added a page of news items from Washington. These are taken from the bulletins of the A.M.A. office in Washington, and pertain mostly to legislative news.

"Committee Pages" have appeared in some issues this year. These are intended to highlight the programs of the various committees of the state association, especially when such programs concern a large segment of our membership and when the committee activity has a high public relation value.

We regret that Editor Emeritus Dr. E. M. Shanklin has been prevented from more active participation in the affairs of THE JOURNAL, and look forward to the time when he will again be active.

It is a pleasure to acknowledge with thanks the assistance of Mr. Ray E. Smith, Dr. A. W. Cavins, and each member of the Editorial Board. Mrs. Isabella Rowlison, editorial secretary, and Miss Persis MacDonald, have contributed efficiently and unselfishly to the management of the publication office. We are indebted to all members of the staff for suggestions and advice, and for much hard work.

FRANK B. RAMSEY, M.D., *Editor*

COMMITTEES ON CONVENTION ARRANGEMENTS

RECEPTION COMMITTEE: Members of the Orange County Medical Society.

VETERANS' AFFAIRS COMMITTEE: Co-chairmen, Nicholas E. Keseric, French Lick, H. L. Miller, West Baden.

GOLF TOURNAMENT COMMITTEE: Chairman, Robert R. Acre; W. L. Daves, William Ritchie, C. C. Herzer, A. F. Clements, Robert Allyn Royster, C. A. Hartley, Jr., all of Evansville.

TRAPSHOOT COMMITTEE: Chairman, John K. Spears, Paoli, C. W. Cullnane, Evansville, and H. T. Combs, Evansville.

WOMEN'S ENTERTAINMENT COMMITTEE: Co-chairmen, Mrs. W. Russell Springstun and Mrs. E. L. Fitzsimmons, Evansville; Mrs. Ray H. Burnikel, Mrs. C. Curtis Young, Jr., Mrs. Willard T. Barnhart, Mrs. Weston A. Heinrich, Mrs. C. C. Herzer, Mrs. John C. Slaughter, Mrs. Daniel C. Tweedall, Mrs. George W. Willison, all of Evansville; Mrs. Ivan A. Clark, Paoli; Mrs. N. E. Keseric, French Lick; Mrs. B. E. Sugarman, French Lick; Mrs. H. L. Miller, West Baden.

WOMEN PHYSICIANS: Chairman, G. Irene Polhemus, New Albany.

EXECUTIVE COMMITTEE: All members of all committees on convention arrangements.

REFERENCE COMMITTEES—1950

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Carl Henning, Hanover (Jefferson)
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Bert Ellis, Indianapolis (Marion)
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John S. Hash, Noblesville (Hamilton)
F. R. N. Carter, South Bend (St. Joseph)
O. H. Stewart, Aurora (Dearborn-Ohio)
O. T. Scamahorn, Pittsboro (Hendricks)

7. Amendments to Constitution and By-Laws:

Cleon A. Nafe, Indianapolis (Marion), Chairman
Augustus P. Hauss, New Albany (Floyd)
J. R. Nash, Albion (Noble)
G. B. Wilder, Anderson (Madison)
I. E. Huckleberry, Salem (Washington)

8. Reports of Officers:

M. E. Glock, Fort Wayne (Allen), Chairman
D. D. Dickson, Greensburg (Decatur)
Richard P. Good, Kokomo (Howard)
S. J. Petronella, East Chicago (Lake)
James F. Reilly, Vincennes (Knox)

9. Committee on Credentials:

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Milton Omstead, Petersburg (Pike)
Carl F. Briggs, Sullivan (Sullivan)
W. G. Pippenger, Brook (Jasper-Newton)
William Dannacher, Wabash (Wabash)

10. Committee on Miscellaneous Business:

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John M. Paris, New Albany (Floyd)
Maurice V. Kahler, Indianapolis (Marion)
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H. P. Graessle, Seymour (Jackson)

HOUSE OF DELEGATES
INDIANA STATE MEDICAL ASSOCIATION
French Lick Springs

September 25, 26 and 27, 1950

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STEUBEN	
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Edgar Weber, Evansville	Joe McCool, Evansville
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E. O. Nay, Terre Haute	W. C. Kunkler, Terre Haute
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William Dannacher, Wabash	Francis Mills, Wabash
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W. C. Stover, Boonville	I. L. Faith, Newburgh
WASHINGTON	
I. E. Huckleberry, Salem	J. P. Gilliatt, Salem
WAYNE-UNION	
Harry Ross, Richmond	Glen W. Lee, Richmond
Will Thompson, Liberty	James F. Lewis, Liberty
WELLS	
A. C. Nickel, Bluffton	Truman E. Caylor, Bluffton
WHITE	
WHITLEY	
B. F. Pence, Columbia City	Otto F. Lehmberg, Columbia City

SCIENTIFIC EXHIBITS

Clyde G. Culbertson, M.D., Indianapolis, Chairman
Thurman B. Rice, M.D., Indianapolis
Milton Omstead, M.D., Petersburg
C. Philip Fox, M.D., Washington
Irvin H. Scott, M.D., Sullivan

1. **Organization and Program.**
   American Cancer Society
2. **Your Health Department.**
   Indiana State Board of Health
3. **Indiana Academy of General Practice.**
   Indiana Chapter of the American Academy of General Practice
4. **The Carotid Angiogram.**
   William R. Chambers, M.D., South Bend
5. **The Pharmacy and the Physician.**
   Indiana Pharmaceutical Association
6. **Diagnostic Tests.**
   Mechanical Quackery.
   Voluntary Health Insurance.
   Medical Education.
   American Medical Association
7. **"Microradiography."**
   Caylor-Nickel Clinic
   Wallace S. Tirman, M.D., Charles E. Caylor, A.B., Harry S. Banker, M.D.
8. **The Etiological Diagnosis of Heart Disease.**
   Indiana Heart Foundation
9. **Clinical Laboratory Procedure Notebook.**
   Department of Clinical Pathology
   Indiana University Medical Center
10. **Six Ways Your Tuberculosis Association Works for You.**
    Indiana Tuberculosis Association
11. **Unusual Superficial Fungous Infections Due to Microsporon Fulvum.**
    Department of Dermato-Syphilology of General Hospital, Indianapolis, and The Alembert Winthrop Brayton Skin and Cancer Foundation.

DATA FROM PREVIOUS SESSIONS

Year	Session	Place	Registration	Year	Session	Place	Registration
1908	59th	French Lick	312	1929	80th	Evansville	814
1909	60th	Terre Haute	421	1930	81st	Fort Wayne	1,115
1910	61st	Fort Wayne	450	1931	82nd	Indianapolis	1,033
1911	62nd	Indianapolis	748	1932	83rd	Michigan City	904
1912	63rd	Indianapolis	590	1933	84th	French Lick	637
1913	64th	West Baden	312	1934	85th	Indianapolis	1,814
1914	65th	Lafayette	527	1935	86th	Gary	1,011
1915	66th	Indianapolis	646	1936	87th	South Bend	1,150
1916	67th	Fort Wayne	381	1937	88th	French Lick	1,154
1917	68th	Evansville	270	1938	89th	Indianapolis	1,751
1918	69th	Indianapolis	388	1939	90th	Fort Wayne	1,332
1919	70th	Indianapolis	---	1940	91st	French Lick	1,064
1920	71st	South Bend	421	1941	92nd	Indianapolis	1,890
1921	72nd	Indianapolis	550	1942	93rd	French Lick	706
1922	73rd	Muncie	522	1943	94th	Indianapolis	1,323
1923	74th	Terre Haute	823	1944	95th	Indianapolis	1,584
1924	75th	Indianapolis	1,012	1945	96th	French Lick	922
1925	76th	Marion	800	1946	97th	Indianapolis	2,240
1926	77th	West Baden	900	1947	98th	French Lick	1,618
1927	78th	Indianapolis	1,500	1948	99th	Indianapolis	2,681
1928	79th	Gary	892	1949	100th	Indianapolis	3,371

TECHNICAL EXHIBITORS

AKRON SURGICAL HOUSE, Inc.
221-223 N. PENNSYLVANIA STREET
INDIANAPOLIS, INDIANA

BOOTH 46

The Akron Surgical House, Inc., will have a display in Booth No. 46 at the meeting at French Lick this year. Some of the latest styles and models in equipment and instruments will be shown, which we believe will be of interest to those who visit our display.

A. S. ALOE COMPANY
1831 OLIVE ST., ST. LOUIS 3, MO.

BOOTH 44

Your Aloe representative will be happy to welcome you at Booth No. 44. He has on display a representative cross-section of the surgical and laboratory equipment and supplies stocked by the "world's largest surgical supply house." Featured are many new items which you will want to see and have demonstrated.

AMERICAN HOSPITAL SUPPLY CORPORATION
2020 RIDGE AVENUE, EVANSTON, ILLINOIS

BOOTH 32

American Hospital Supply Corporation will display and demonstrate the full line of the Baxter Laboratories to include intravenous solutions and blood transfusion equipment with all expendable accessories. A new Travamin solution (Protein Hydrolysate) both with and without alcohol, and Histamine (Horton Formula) will be among the special solutions shown. There will also be the full line of high-titred blood typing and blood grouping serums which are used predominantly throughout the country because of their fast action; Tomac Oral Protein Supplement, an extremely **palatable** product with 70 percent protein and only an 18 percent carbohydrate content. Of especial importance is the Krasno-Ivy Flicker Photometer, the new instrument which was shown at the A.M.A. Convention recently in San Francisco. This instrument is used for early diagnosis of some types of heart disease and for evaluating the therapeutic value of medications prescribed for heart disease patients. It is urged that the doctors visit the AMERICAN booth to see the demonstrations of these specialty products.

AMES COMPANY, INC.
ELKHART, INDIANA

BOOTH 15

BUMINTEST reagent tablets, Ames Company's new test for albumin, will be demonstrated at the Ames booth. Ames Company's representatives will also be demonstrating CLINITEST, ACETEST, and HEMATEST, simplified tests for the detection of urine-sugar, acetone bodies, and occult blood.

Our representatives will be glad to discuss DECHOLIN and DECHOLIN SODIUM, the standard hydrocholeretic agents for the treatment of biliary tract diseases.

Mr. C. O. Kampf, Mr. B. E. Simmons and Mr. G. F. Norris will be in attendance.

THE ARMOUR LABORATORIES
1425 WEST 42ND STREET, CHICAGO 9, ILLINOIS

BOOTH 6

THE BAKER LABORATORIES, INC.
4614 Prospect Ave., Cleveland 3, Ohio

BOOTH 33

Baker's Modified Milk (Liquid and Powder) is made from Grade A Cows' milk, fortified, adjusted and processed to obtain more efficient nutritive action and to insure better tolerance. Baker's has an adjusted protein, two carbohydrates, a modified fat, vitamins, soluble mineral salts and iron coupled with simplicity of preparation and low cost.

BROOKS APPLIANCE COMPANY
5 NORTH WABASH AVE., CHICAGO, ILLINOIS

BOOTH 10

Doctors will want to visit our booth and inspect the quality bandages which will be on display. We shall feature Polyestol, an elastic transparent bandage which when applied releases Methyl Salicylate by absorption into the blood stream at an approximate rate of 3.5 mgm. per square inch per hour at normal body temperature. The medicated Primer plus Dalzoflex Elastic Adhesive may be used to advantage in treating leg ulcers, phlebitis, et cetera. Mr. Ayer will describe in detail the technique of application. Proctologic instruments, syringes and elastic hosiery will also be displayed.

BURROUGHS WELLCOME & CO. (U.S.A.), INC.
TUCKAHOE, NEW YORK

BOOTH 50

"B. W. & Co." will feature a completely **new type** antihistaminic, "PERAZIL" brand Chlorcyclizine Hydrochloride. "PERAZIL" **differs chemically** in that it is a piperazine, rather than a conventional ethylenediamine compound, and a single dose provides 12 to 24 hour action. We will also feature "Wellcome" brand GLOBIN INSULIN, the accepted intermediate-acting insulin, and DIGOXIN, for safe, predictable digitalization.

CAMEL CIGARETTES
ONE PERSHING SQUARE
NEW YORK 17, N. Y.

BOOTH 20

CAMEL Cigarettes will feature color slides of background data from their newest research. After weekly examinations of the throats of hundreds of men and women smoking CAMEL Cigarettes exclusively for thirty days, throat specialists reported "Not one single case of throat irritation due to smoking CAMELS."

THE CENTRAL PHARMACAL COMPANY
SEYMOUR, INDIANA

BOOTH 31

Members of the Indiana State Medical Association and their guests will enjoy a friendly welcome when they visit our exhibit, which will feature a new and improved Theophylline compound, Theophylline-Sodium Glycinate (Synophylate). The advent of this superior compound made possible the effective oral treatment of several asthmatic and cardiac conditions, since really adequate dosage of Theophylline may be administered with maximum therapeutic effect and minimum undesirable side-actions.

Also displayed will be the original and first Council Accepted triple-sulfa preparations in Suspension, Palatab and Tablet forms.

The third section of our display will feature Aqueous Suspensions of Natural Estrogenic Substances (Estronol) that are of special interest since no suspending media is employed, and the products are free from the danger of allergic reactions due to suspending agents or foreign substances of any type.

CHICAGO PHARMACAL COMPANY
5547 N. Ravenswood Ave., Chicago

BOOTH 28

The Chicago Pharmacal Company will take pleasure in greeting through its Indiana representatives all patrons of the company.

At this meeting the Chimedic line will feature Alpha-Estradiol in micro suspension, Digitoxin and a distinct improvement in calcium therapy in parenteral form, namely Calcium Levulinate.

We extend a cordial greeting to all physicians attending the exhibit.

CIBA PHARMACEUTICAL PRODUCTS, INC.
LAFAYETTE PARK, SUMMIT, NEW JERSEY

BOOTH 35

Ciba Pharmaceutical Products, Inc., Summit, New Jersey, invites you to visit its exhibit which will feature PRISCOLINE Hydrochloride, an adrenergic and sympathicolytic agent that produces peripheral vasodilatation.

Representatives in attendance will gladly discuss the role of PRISCOLINE in the treatment of peripheral vascular disease.

THE COCA-COLA COMPANY
ATLANTA, GEORGIA

BOOTH 13

CURTIS & FRENCH, INC.
1108 N. PENN. ST., INDIANAPOLIS 2, INDIANA

BOOTH 1

Jack Curtis, Mac McCain, and Bob Ettinger will be on hand to welcome all of our old and new friends. New equipment of interest to all will be displayed.

DOHO CHEMICAL CORPORATION
100 Varick St., New York 13, N. Y.

BOOTH 30-A

The Doho Chemical Corporation and its subsidiary, Mallon Chemical Corporation, makers of Auralgan, O-Tos-Mo-San and Rectalgan, are proud to announce their new nasal decongestant, Rhinalgan—a balanced formulation of two active chemical compounds that gives prolonged vasoconstriction—used as a spray, in our patented Dohony Spray-O-Mizer (combination dropper and spray)—pleasant tasting, with no systemic effect (pressor or respiratory), and can be safely used for infants and children.

Our representatives will be happy to explain the merits of Rhinalgan and distribute samples of this innovation.

DAIRY COUNCILS OF INDIANA
115 E. MARKET ST., INDIANAPOLIS, IND.

BOOTH 23

You are cordially invited to visit the Dairy Council booth and examine our health education materials.

The exhibit is sponsored by the Dairy Councils of Evansville, Fort Wayne, Indianapolis, and South Bend. These units are affiliated with the National Dairy Council of Chicago, which is the health education organization of the dairy industry.

Dairy Council services and materials are free of charge in the localities which have affiliated units.

DICK X-RAY COMPANY, INC.
443 N. PENN. ST., INDIANAPOLIS, AND
3376 OLIVE ST., ST. LOUIS, MO.

BOOTH 37

The Dick X-Ray Company will have on display: Westinghouse X - Ray Equipment—Liebel-Flarsheim Short Wave Machines—Cambridge "Simpli-trol" Portable Electro - cardiograph — Fluorescent Viewers — Physiotherapy Equipment.

ELECTRONIC SURGICAL EQUIPMENT CO., INC.
TWENTY-THIRD AND ARCH STREETS
PHILADELPHIA 3, PA.

BOOTH 4

Exhibited in Booth 4 is the RADIOSURG SCALPEL Operating Unit, a portable radio frequency surgical apparatus of advanced engineering design. This precision instrument permits the use of varied electronic surgical methods to meet the minor surgical needs of the general physician, proctologist, gynecologist, or surgeon. Constructed according to exacting specifications, and employing a new electronic principle of the fully rectified radio current, it supplies ideal current characteristics for all these surgical interventions.

Representatives in charge: W. A. Coles, W. R. Coles, and J. W. Price.

FREEMAN X-RAY COMPANY
4647 N. CICERO AVENUE, CHICAGO, ILLINOIS

BOOTH 17

GERBER PRODUCTS COMPANY
FREMONT, MICHIGAN

BOOTH 11

J. E. HANGER, INC.
1407 N. ILLINOIS STREET, INDIANAPOLIS 2, IND.

BOOTH 26

J. E. Hanger, Incorporated, manufacturers of prosthetic appliances, wish to invite you to visit our exhibit to see and discuss the various types of lower and upper extremities. We are happy to announce that the Vacuum Socket Limb has passed the experimental stage and has become very popular with both the Veterans Administration and the general public. Also available is the newly developed floating knee for above-knee prostheses. It promotes more natural knee motion, and has proven very satisfactory to many wearers.

Our company wishes to express its thanks for your past consideration and cooperation. We will continue to give you the best possible service, as we have always endeavored to do in the past.

HOFFMAN-LaROCHE, INC.
ROCHE PARK, NUTLEY 10, NEW JERSEY

BOOTH 5

Roche will feature GANTRISIN, the new sulfonamide which has outstanding therapeutic advantages. GANTRISIN is distinguished by comparatively high solubility even in neutral and slightly acid solutions. It is not likely to cause crystalluria and it does not require concomitant alkali therapy. GANTRISIN is highly effective in the treatment of systemic and urinary tract infections.

Why not stop at the Roche booth where members of the field staff will be in attendance to tell you more about GANTRISIN, the radically different sulfonamide.

C. B. KENDALL COMPANY
2039 MADISON AVENUE, INDIANAPOLIS 6, IND.

BOOTH 18

C. B. Kendall Company cordially invites all members of the Indiana State Medical Association to visit our technical exhibit. Literature and samples of new pharmaceutical specialties which are currently detailed and advertised to the profession will be available. Members of the Kendall detail staff will welcome your interest and questions relative to our specialties.

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

BOOTH 12

You are cordially invited to visit our exhibit in Booth No. 12, where you will find representatives who are prepared to give you the latest information on Lederle products.

ELI LILLY AND COMPANY
INDIANAPOLIS 6, IND.

BOOTH 22

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit located in Space No. 22. The display for 1950 features a presentation on the incidence and potential number of diabetics in America. The attending representatives will be pleased indeed to assist visiting physicians in every way possible.

Lilly personnel who will be in attendance are: Messrs. C. W. Clark and Harley Chastain.

LINCOLN LABORATORIES, INC.
Decatur, Illinois

BOOTH 48

Lincoln Laboratories, Inc., will feature several of their leading parenterals together with tablet specialties. Included in the group of parenterals will be the aqueous suspensions of several of the steroid hormones. Trained representatives will be on hand to discuss these products. Literature and samples will be available.

M & R DIETETIC LABORATORIES
8 E. LONG STREET, COLUMBUS 16, OHIO

BOOTH 49

Similac Division, M & R Dietetic Laboratories, Inc., Booth Number 49, will display Similac, a food for infants, and Cerevim, a cereal food. Our representative will appreciate the opportunity to discuss the merit and suggested application for both normal and special feeding cases.

THE S. E. MASSENGILL COMPANY
BRISTOL, TENNESSEE

BOOTH 8

The S. E. Massengill Company invites you to visit Booth No. 8 where a number of specialty preparations are on display. Your particular attention is called to a few of these: Suspension Aldiazol-M, Livitamin, Liquid and Capsules and F. C. Pasem Sodium.

Suspension Aldiazol-M combines sulfadiazine and sulfamerazine in supplying 0.5 gm. of total sulfonamides per teaspoonful, in combination with sodium citrate. This product is one of the safest and therapeutically effective sulfonamide combinations available today.

The Livitamin products combine liver, iron and the principal B complex, fortified with vitamin B_{12}. Rapid regeneration and correction of the blood picture is usual.

F. C. Pasem Sodium is the Massengill sodium salt of para-aminosalicylic acid, an outstanding development in the treatment of tuberculosis.

Our medical service representatives Messrs. E. L. Smith, H. C. Catron, and M. W. Pully, will be pleased to discuss any Massengill preparations with you, and you may register for samples and literature.

MEAD JOHNSON & COMPANY
EVANSVILLE 21, IND.

BOOTH 34

Dextri-Maltose, Oleum Percomorphum, Pablum, Pabena, Olac and other Mead Products used in infant nutrition will be on display at the Mead Johnson Exhibit at the Indiana State Medical Association Meeting. Protenum, a new high protein product, will be displayed. Also, Lonalac, for low sodium diets. Our representatives at the Exhibit will be glad to discuss with you the new improvements of Amigen and Amisets.

THE MEDICAL PROTECTIVE COMPANY
FT. WAYNE, INDIANA

BOOTH 52

The Medical Protective Company invites the members of the Medical Society of the State of Indiana to visit our exhibit and discuss with our representative how his company meets the exacting requirements of adequate liability protection which are peculiar to the professional liability field.

MUTUAL MEDICAL INSURANCE, Inc.
400 TEST BUILDING, INDIANAPOLIS

BOOTH 55

Mutual Medical Insurance, Inc. (Blue Shield—The Doctors' Plan) will have its exhibit at the top of the West stairs leading to the mezzanine. The booth number is 55.

"Thanks a Million, Doctor" will be the theme of the modernistic display which will feature the record of achievements of the Indiana Plan, since its authorization by the House of Delegates of the ISMA.

Representatives of the Plan will be on hand at all times to answer questions and be helpful in any way possible. Special materials will be distributed explaining the operation of the Plan, the benefits it affords the physician and the public, and showing the growth of the Plan in membership during the past four years.

Blue Shield will celebrate its fourth anniversary at the same time. During four years of operation, well over 450,000 people have joined the Plan and more than $4,200,000 has been paid out to Indiana physicians for service rendered these members.

Dr. Walter U. Kennedy, New Castle, is president of The Blue Shield Plan; Dr. W. Harry Howard, Hammond, is vice-president; Dr. Walter L. Portteus, Franklin, is secretary; and Dr. A. F. Weyerbacher, Indianapolis, treasurer. These four, with Dr. C. J. Clark, Indianapolis, Dr. Wemple Dodds, Crawfordsville, and Dr. Jesse E. Ferrell, Fortville, serve as the executive committee for the Plan.

Administration of The Blue Shield Plan is under the direction of R. S. Saylor, Executive Vice-President, 400 Test Building, Indianapolis.

THE NATIONAL DRUG COMPANY
4663 STENTON AVE., PHILADELPHIA

BOOTH 40

You are cordially invited to attend the booth of The National Drug Company. On display will be the following products: RESINAT (Council Accepted) newly accepted therapy for peptic ulcer; PROTINAL POWDER (Council Accepted) a delicious tasting, whole protein-carbohydrate mixture; AVC IMPROVED, a vaginal cream effective in moniliasis as well as trichomonas; NATOLONE, steroid hormone therapy in arthritis; AMMIVIN (Khellin) a potent coronary vasodilator; BENAT with B-12, for growth stimulation and general nutritional deficiencies. Literature and samples on these products will be available.

MAURICE NATENBERG,
Publisher's Representative
912 GORDON TERRACE, CHICAGO 13, ILL.

BOOTH 7

My exhibit will include the publications of the following firms:

Appleton-Century-Crofts, Inc.
Grune & Stratton, Inc.
Oxford University Press
The Williams & Wilkins Company
The Year Book Co.

ORTHO PHARMACEUTICAL CORPORATION
RARITAN, NEW JERSEY

BOOTH 45

Ortho cordially invites you to visit their exhibit at booth No. 45 where the full line of Ortho Gynecic specialties will be on display including the new Ortho Kit. This Kit is a dainty, discreet, woven plastic, zipper bag containing the essentials of proper conception control. Also on display will be Masse' Nipple Cream, a new approach to the treatment and prophylaxis of cracked nipples. Ortho representatives will be on hand to welcome you and discuss these products with you.

PARKE, DAVIS & COMPANY
DETROIT 32, MICH.

BOOTH 41

Medical Service Members of the PARKE, DAVIS & COMPANY Staff will be in daily attendance at our Commercial Exhibit for consultation and discussion of the various Products listed in our Pharmaceutic, Antibiotic, and Biologic Catalog. Important Specialties, such as Chloromycetin, Penicillin S-R, Benadryl, Vitamins, Oxycel, Thrombin Topical, Influenza Virus Vaccine, and others will be featured. You are most cordially invited to visit our Exhibit with the assurance that your personal interest will indeed be very much appreciated.

PET MILK COMPANY
1401 Arcade Building
St. Louis 1, Missouri

BOOTH 14

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

PHILIP MORRIS & COMPANY LTD., INC.
100 PARK AVENUE, NEW YORK, N. Y.

BOOTH 27

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

PICKER X-RAY CORPORATION
239 K. OF P. BLDG., INDIANAPOLIS 4

BOOTH 24

PICKER X-RAY CORPORATION will exhibit the new practical x-ray unit at a popular price—THE METEOR. A patented tilting table top feature provides for rapid and easy conversion from radiography to fluoroscopy in either horizontal or vertical positions.

PITMAN-MOORE COMPANY
1220 MADISON AVENUE, INDIANAPOLIS 6, IND.

BOOTH 43

Booth 43 will feature a number of Pitman-Moore research products which have won ready acceptance from the medical profession. Pitman-Moore medical representatives for the state will be present to greet their friends in the profession, and members of the scientific staff will be in attendance to answer questions concerning the company's products and its research activities.

REX TYPEWRITER EXCHANGE
207 Massachusetts Ave., Indianapolis, Ind.

BOOTH 42

Be sure to visit the Rex Typewriter Exchange, Booth No. 42. We will have on display all the latest models of "Webster Chicago Wire Recorders." Stop and have your voice recorded on wire, and learn what a time-saver one of these machines can be in your office. Over 50 percent of the machines we have sold have been to men in the medical field. The New Model 18 will fill all your dictating and transcribing needs. Curt Benner will have charge of the display.

RICKRICH SURGICAL SUPPLY COMPANY
801-803 W. INDIANA ST., EVANSVILLE 10, IND.

BOOTH 3

Rickrich Surgical Supply Company cordially invites you to visit their exhibit at Booth No. 3. New surgical and diagnostic instruments will be on display. See the "Cardi-All," a direct writing electrocardiograph at moderate cost.

A. H. ROBINS COMPANY, INC.
RICHMOND, VIRGINIA

BOOTH 36

The A. H. Robins Company display is featuring the sedative-antispasmodic, DONNATAL; the antirheumatic, PABALATE; ENTOZYME, digestant with the unique "peptomatic" action; and the highly effective antitussive-expectorant, ROBITUSSIN. Robins' Medical Service Representatives, J. H. Kirby, Dwaine W. Otoupal, and Gerald V. Loder, will welcome the privilege of discussing with physicians attending the Assembly these and other products in the company's line of prescription specialties.

SANDOZ PHARMACEUTICALS
DIVISION OF SANDOZ CHEMICAL WORKS, INC.
68-72 CHARLTON STREET, NEW YORK 14, N. Y.

BOOTH 51

Physicians attending the Indiana State Medical Association convention are cordially invited to visit the Sandoz Pharmaceuticals display which will feature the following:

CAFERGONE—the first effective oral preparation for the treatment of migraine and related headaches.

BELLERGAL—a time-tested preparation for use in functional disorders.

Other products displayed at this convention are Belladenal, Mesantoin, Dihydroergotamine (D.H.E. 45) and Ipesandrine.

W. B. SAUNDERS COMPANY
WEST WASHINGTON SQUARE,
PHILADELPHIA 5, PA.

BOOTH 47

We invite all doctors attending the meeting of the Indiana State Medical Association to visit our exhibit, where we will display a complete line of our books including Hyman's "Integrated Practice of Medicine," Bockus' "Postgraduate Gastro-enterology," Wells' "Clinical Pathology," "Cytologic Diagnosis of Cancer," Wolff's "Electrocardiology," Mitchell and Nelson's "Pediatrics," Hausers "Diseases of the Foot," Boies' "Otolaryngology," Nesselrod's "Proctology," Williams' "Textbook of Endocrinology," Custer's "Atlas of Blood and Bone Marrow," Sunderman and Boerner's "Normal Clinical Values," Friedberg's "Diseases of the Heart," Janney's "Medical Gynecology," Levine and Harvey's "Clinical Auscultation of the Heart," Dry's "Cardiology," Shanks' "Textbook of X-ray Diagnosis," Maingot's "Techniques in British Surgery," Smith's "Plastic and Reconstructive Surgery," new (sixth) edition Curtis-Huffman's "Textbook of Gynecology," new (second) edition Pullen's "Medical Diagnosis," and many other new books and new editions.

G. D. SEARLE & COMPANY
P. O. BOX 5110, CHICAGO 80, ILL.

BOOTH 30

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Banthine, the true anticholinergic drug for the treatment of Peptic Ulcers; Dramamine, for the prevention and active treatment of motion sickness; and Alidase, Searle brand of Hyaluronidase which permits subcutaneous feedings at intravenous speed. Other time-proven products of Searle Research on which information may be obtained are Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine, and Pavatrine with Phenobarbital.

SEVEN-UP BOTTLING COMPANY
INDIANAPOLIS

BOOTH 29

SPENCER, INCORPORATED
NEW HAVEN 7, CONN.

BOOTH 2

On display will be Spencer Supports designed for each individual patient to improve Body Mechanics and thus aid and assist in treatment.

Your special attention is invited to:

1. Supports for relief of Chronic Arthritis.
2. Supports for relief of Angina Pectoris.
3. Supports for children with Post-Polio weaknesses.
4. Spencer Breast Supports designed for each patient, to supply natural support and thus improve circulation and help keep breast tissues healthy—and Spencer Breast Supports with Breast Forms for Mastectomy patients.
5. Spencer's popular Blood Pressure Sleeve.

THE UPJOHN COMPANY
Kalamazoo

BOOTH 25

The Upjohn exhibit will present the anticoagulant family: Heparin, Depo-Heparin, and Dicumarol, with particular emphasis placed upon Depo-Heparin.

When heparin is prepared in a gelatin vehicle (Depo-Heparin) and administered intramuscularly, markedly prolonged effects are obtained. A single injection of 1 cc. (200 mg.) of Depo-Heparin will prolong the blood coagulation time for about twenty-four hours.

U. S. VITAMIN CORPORATION
250 EAST 43RD STREET, NEW YORK 17, N. Y.

BOOTH 9

Exhibit demonstrates the greatest vitamin technicological advance of the present decade—"oil-in-water" multivitamin solutions—includes Vi-Syneral Injectable which makes available for the first time in pharmaceutical history an aqueous parenteral multivitamin solution, ready for immediate injection; also, the original oral aqueous multivitamin formula, Vi-Syneral Vitamin Drops—since 1943.

Also see and taste for yourself the new and different sodium-free salt substitute, CO-SALT . . . actually tastes like salt, looks like salt and sprinkles like salt . . . a great boon to your patients on restricted sodium intake.

Professional samples and literature distributed on these products along with our full line of nutritional specialties, including Methischol, Tri-Sulfanyl, Vi-Syneral Capsules, Poly-B, Vi-Litron, Hypervitam, Lipo-Heplex and others.

VAISEY-BRISTOL SHOE CO., INC.
38-42 SCIO STREET, ROCHESTER 3, NEW YORK

BOOTH 39

VANPELT AND BROWN, INCORPORATED
1322 East Main St., Richmond 4, Va.

BOOTH 19

VanPelt and Brown extend a cordial invitation to visit their exhibit, where representatives will be happy to answer questions and supply clinical samples of their products.

THE WARREN-TEED PRODUCTS COMPANY
582 W. GOODALE ST., COLUMBUS 8, OHIO

BOOTH 21

The Warren-Teed Products Company will feature a new exhibit which will be used for the first time at the Indiana State Medical Meeting.

Physicians are cordially invited to visit our new exhibit at booth number 21, which will feature Epsilan Phosphate, a recent development of our research laboratories. Epsilan Phosphate has proved of value in raising the antithrombin level, which is important in the prevention of postoperative thrombo-emboli. Research and clinical studies were conducted at Tulane Medical School, Department of Surgery, under the direction of Drs. Ochsner, Kay, Hutton, and Balla. Other interesting, and important items to the medical profession will be displayed. Descriptive literature on Epsilan Phosphate, as well as other items displayed, will be available at our booth. Our representatives will be pleased to assist registrants in any way possible.

WAYNE PHARMACAL SUPPLY COMPANY
349 W. WAYNE ST., FORT WAYNE 2, INDIANA

BOOTH 16

The Wayne Pharmacal Supply Company, with stores in Fort Wayne and South Bend, will exhibit many items of interest to the physician.

We will show the Microtherm, a radar diathermy. This machine will not interfere with television.

The Safe-T-Tilt baby bottle holder will be shown for the first time at a convention. This apparatus will hold a baby bottle in any position. This is a real asset to any hospital.

We will also exhibit the new McKesson Cardiofax, a direct writing E.K.G. machine. Be sure to see the latest in this field.

Many miscellaneous items will be shown, such as surgical instruments, diagnostic equipment, etc.

WHITE-HAINES OPTICAL COMPANY
HUME MANSUR BUILDING
INDIANAPOLIS, INDIANA

BOOTH 53

WINTHROP-STEARNS, INC.
170 VARICK STREET, NEW YORK 13, N. Y.

BOOTH 38

WINTHROP-STEARNS, INC., New York, extends a cordial invitation to visit booth No. 38, where representatives will be on hand to discuss the latest therapeutic contributions made by this firm. Featured will be MILIBIS (R), new virtually nontoxic amebacide; ARALEN (R), effective antimalarial, also specific for extra-intestinal (hepatic) amebiasis; ISUPREL (R), efficient and convenient bronchodilator, Tablets for sublingual use, solution for inhalation; MEBARAL (R), sedative and anti-epileptic, produces tranquility virtually without drowsiness; NEOCURTASAL (R), sodium-free seasoning agent.

VISIT THE TECHNICAL EXHIBITS AT FRENCH LICK

The technical exhibitors at our annual convention contribute a major share of the expense of this meeting. Show your appreciation of their support by registering with each exhibitor.

Announcements

SECTION MEETINGS

The **Section on General Practice** will have a luncheon at 12:00 noon on Tuesday, September 26, in the main dining room.

The **Section on Obstetrics and Gynecology** will meet in the main convention hall at 12:00 noon on Tuesday, September 26, for election of section officers for 1951. Dr. Charles C. Crampton, of Delphi, and Dr. Andy Hall, of Mount Vernon, Illinois, will speak.

The **Section on Ophthalmology and Otolaryngology** will meet in the main convention hall at 4:30 p.m. on Tuesday, September 26, for election of section officers for 1951.

The **Section on Medicine** will meet at 11:45 a.m. on Wednesday, September 27, in the main convention hall. Section officers for 1951 will be elected at this time.

The **Section on Anesthesia** will hold a luncheon meeting in the Blue Room at 12:00 noon on Wednesday, September 27, when section officers for 1951 will be elected. Dr. R. M. S. Barrett, of St. Louis, will speak at this meeting.

The **Section on Surgery** will meet in the main convention hall at 4:30 p.m. on Wednesday, September 27, for election of section officers for 1951.

TUBERCULOSIS COMMITTEES LUNCHEON

The Committee on Tuberculosis will hold a joint meeting of County Tuberculosis Committees and members of the Indiana Chapter of the American College of Chest physicians in the Round Room at noon on Tuesday, September 26. Any other physicians who may be interested are also welcome. The speaker at this meeting will be Dr. J. Vincent Sherwood, of Fort Wayne, whose subject will be "The A/G Ratio Correlated with Pulmonary Tuberculosis."

COUNTY MEDICAL SOCIETY OFFICERS BREAKFAST

The Committee on Conference of County Medical Society Officers will have a breakfast meeting at 7:30 a.m. on Wednesday, September 27, in Parlor A.

COMMITTEE ON INDUSTRIAL HEALTH BREAKFAST

A breakfast meeting of the Committee on Industrial Health will be held in Parlor B at 7:30 a.m. on Wednesday, September 27.

SPECIAL SALE OF CENTENNIAL BOOK

Copies of ONE HUNDRED YEARS OF INDIANA MEDICINE, issued a year ago in connection with the centennial convention of the state medical association, will be sold at the registration desk at the French Lick Springs hotel for $2.50 each. Only a few of these books remain unsold. This is your last chance to get a copy.

ANNUAL GOLF TOURNAMENT

The Annual Golf Tournament will begin at 8:00 a.m., on Monday, September 25, at the French Lick Hill Course. This will be an eighteen hole, low gross, low net, and blind bogie medal play.

ANNUAL TRAP AND SKEET SHOOT

The Annual Trap and Skeet Shoot will be held at French Lick Springs Trap and Skeet Club at 9:00 a.m. on Monday, September 25.

EDITORIAL BOARD MEETING

A meeting of the Editorial Board of THE JOURNAL of the Indiana State Medical Association will be held at 10:00 a.m., on Monday, September 25, in Room 143, on the main floor of the French Lick Springs Hotel.

CLASS REUNIONS

The twentieth anniversary meeting of the class of 1930 of Indiana University School of Medicine will be held at 5:00 p.m. on Monday, September 25, in the Game Room.

The class of 1935 of Indiana University School of Medicine will hold a reunion at noon on Wednesday, September 27, in parlors A and B, at French Lick Springs Hotel.

The class of 1907 of Indiana University School of Medicine will hold a reunion luncheon on Wednesday, September 27, at French Lick Springs Hotel, during the state convention. Luncheon room announcement will be made on the bulletin board in the lobby of the hotel.

INDIANA ASSOCIATION OF PATHOLOGISTS MEETING

A meeting of the Indiana Association of Pathologists will be held in the Radio Room at 10:00 a.m. on Wednesday, September 27.

STAG PARTY

A supper, smoker and stag party will be held in the main dining room at 7:00 p.m. on Monday, September 25.

CONSERVATION OF VISION COMMITTEES BREAKFAST

There will be a breakfast meeting for members of the state and county Conservation of Vision Committees on Tuesday, September 26, at 7:30 a.m., in the Blue Room. Dr. John J. Flick, of Indianapolis, will speak on "Ocular Casualties in Atomic Warfare."

INDIANA ACADEMY OF GENERAL PRACTICE BREAKFAST

A breakfast meeting of officers, board of directors, and chairmen of committees of the Indiana Academy of General Practice will be held in Parlor A, at 7:30 a.m. on Tuesday, September 26.

ORDER YOUR TICKETS FOR THE 1950 INSTRUCTIONAL COURSE NOW!

The schedule of classes for the 1950 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at French Lick Springs Hotel, French Lick, is now complete. All classes are on Monday, September 25, 1950.

Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is $1.00 per class with a maximum charge of $3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now! Classes are filled early!

INSTRUCTIONAL COURSE SCHEDULE

Hrs.	Room A	Room B	Room C	Room D	Room E	Room F
11 to 12	Psychological Management of Patients Dr. K. I. Jeffries Course 1	Diagnosis and Treatment of Respiratory Diseases Dr. R. S. Henry Course 2	Pediatric Problems Dr. R. Hippensteel Course 3	Ear, Nose and Throat Problems Dr. Bert Ellis Course 4	The Backache Problem Dr. C. F. Thompson Course 5	Problems of Hypertension Dr. W. A. Shullenberger Course 6
	NOON RECESS					
1 to 2	Bedside and Office Diagnosis of Cardiac and Vascular Problems Dr. A. T. Stone Course 7	Anemia and Blood Dyscrasias Dr. Philip Kurtz Course 8	Infant Feeding Problems Dr. S. A. Kauffman Course 9	Office Management of Anorectal Diseases Dr. J. W. Ricketts Course 10	Minor Home, Farm and Factory Emergencies Dr. A. K. Harcourt Course 11	Office Diagnosis and Treatment of Common Genitourinary Conditions Dr. John Hendricks Course 12
2 to 3	The Demonstration of a Diagnostic Neurological Examination Dr. E. Vernon Hahn Course 13	Bedside and Office Diagnosis of Cardiac and Vascular Problems Dr. E. P. Tischer Course 14	Problems in the Management of Rheumatic Fever Dr. M. Winters Course 15	The Diagnosis and Treatment of Common Skin Diseases Dr. Don E. Kelly Course 16	Corns, Bunions and Painful Feet Dr. G. W. Batman Course 17	Diagnosis and Management of Common Gynecological Conditions Dr. T. B. Noble, Jr. Course 18
3 to 4	The Demonstration of A Diagnostic Physical Examination Dr. J. O. Ritchey Course 19	The Management of Diabetes Mellitus Dr. O. E. Carter Course 20	Obstetrical Emergencies Dr. G. W. Gustafson Course 21	The Newer Drugs Dr. R. A. Solomon Course 22	Arthritis Dr. W. M. Dugan Course 23	The Management of the Menopause Syndrome Dr. Floyd S. Romberger, Jr. Course 24
4 to 5	The Headache Problem Dr. John H. Greist Course 25	The Examination and Management of Cancerphobia Dr. Ben B. Moore Course 26	Impotence and Infertility Dr. Ernest Rupel Dr. John Spahr Course 27	The Diagnosis and Treatment of Common Skin Diseases Dr. F. Gastineau Course 28	The Treatment of Colitis and Constipation Dr. A. G. Funkhouser Course 29	The Management of Problems of the Elderly Dr. Wm. E. King Course 30

Cut on Dotted Line

APPLICATION BLANK

Instructional Course Committee,
c/o Gordon W. Batman, M.D.,
723 Hume Mansur Building,
Indianapolis 4, Indiana.

Enclosed find check for $1.00; $2.00; $3.00. Please reserve tickets for the following Instructional Courses:

	11:00 A.M.	1:00 P.M.	2:00 P.M.	3:00 P.M.	4:00 P.M.
First choices	No.:	No.:	No.:	No.:	No.:
Second choices	No.:	No.:	No.:	No.:	No.:

(Insert course numbers plainly, please.)

I will pick up my tickets at the Registration Desk, September 25, 1950.

Signed: ....., M.D.

Address: .....

Just in Case You May Forget

1950 Annual Session

Indiana State Medical Association

FRENCH LICK

Monday, Tuesday and Wednesday
September 25, 26 and 27

Write Direct to the Hotel for Your Reservation!

HOTELS AND RATES

French Lick Springs Hotel, French Lick, Indiana
(American Plan)

Single room with bath.....$14.00 per day
Double room with bath.....$12.00 per day per person
Double room with lavatory and toilet .....$10.00 per day per person
Double room with running water .....$ 9.00 per day per person
Parlors .....$12.00 per day

For those persons staying outside the hotel the meal rate will be: Breakfast, $1.50; luncheon, $2.00, and dinner, $3.00, including tickets for the banquet Wednesday night, September 27.

Check-out hours are 11:00 a.m. and 4:00 p.m.

Grand Hotel, French Lick, Indiana
(European Plan)

Rooms with bath on halls—
Double $3.00, $2.50, $2.00
Single $2.00, $1.50, $1.00

Claxton House, French Lick, Indiana
(European Plan)

Rooms with bath on halls—
Double $2.00
Single $1.50

West Baden Springs Hotel, West Baden, Indiana*
(European Plan)

Double room with bath.....$5.00 double; $3.00 single
Double room with toilet (no bath) .....$4.00 double; $2.50 single
Double room with running water only .....$3.50 double; $2.00 single

Be sure to specify type of accommodations, and time of arrival and departure.

Schedule of Events

MONDAY, SEPTEMBER 25

Instructional courses, Council and House of Delegates meetings, golf and trap shoot, party for women at night, and the big stag jamboree.

TUESDAY, SEPTEMBER 26

Scientific papers, morning and afternoon. Dancing at night to music of name band.

WEDNESDAY, SEPTEMBER 27

Scientific papers morning and afternoon. Final meeting of Council and House of Delegates. Annual dinner, with nationally-known humorist as principal speaker.

* West Baden Springs is one mile from French Lick

SUPPLEMENTAL ROSTER OF 1950 MEMBERS
INDIANA STATE MEDICAL ASSOCIATION

Name	City	County
A		
Alexander, Stephen	306 Ben Hur Bldg., Crawfordsville	Montgomery
Atchison, Kenneth C.	Rockport	Spencer
B		
Barrow, John H.	Dale	Spencer
Bethea, D. A.	1021 Fields St., Hammond	Lake
Bitler, C. C.	New Castle	Henry
Bond, George S.	1221 N. Delaware St., Indianapolis	Marion
Borak, W. J.	6151 W. 25th Ave., Gary	Lake
Brauer, A. A.	3528 Main St., E. Chicago	Lake
Brink, C. C.	504 Broadway, Gary	Lake
Buxton, Eva (H)	Rockport	Spencer
C		
Combs, L. W.	Lowell	Lake
Cook, Thomas W.	Toledo Hospital, Toledo 6, Ohio	Delaware-Blackford
Craig, Robert A.	Syracuse	Elkhart
D		
Danieleski, L. J.	738 Broadway, Gary	Lake
Denny, F. C.	Madison	Jefferson
Dierolf, E. J.	504 Broadway, Gary	Lake
E-F		
Ehrman, C. D.	Rockport	Spencer
Friedrich, L. M. (H)	614 E. Third St., Hobart	Lake
G		
Glackman, John C., Jr.	Rockport	Spencer
Goldman, Samuel	1266 Oliver St., Indianapolis	Marion
Greenburg, Rolland	Jasper	Dubois
Gregoline, A. F.	729 Broadway, Gary	Lake
Greist, Henry W. (H)	Monticello	White
Groman, H. C.	137 Rimbach, Hammond	Lake
H-J		
Hoppenrath, W. M.	Elwood	Madison
Jewett, Robert E.	1330 W. Michigan St., Indianapolis 7	Marion
Jolly, W. P.	Richland	Spencer
K-L		
Kerrigan, William T.	Rockport	Spencer
Libbert, Edwin L.	2232 E. Kessler Blvd., Indianapolis 20	Marion
Lukemeyer, St. J.	Jasper	Dubois
M		
Marshall, L. C.	Mt. Summit	Henry
Medcalf, N. L.	Lamar	Spencer
Mervis, F. H.	3414 Michigan Ave., East Chicago	Lake
Miller, Jack B.	4801 S.E. Ankney Street, Portland 15, Oregon	Pike
Mirro, John A.	Commercial Ave., Lowell	Lake
Modisett, Jackson	Madison	Jefferson
Modisett, Marcella	Madison	Jefferson
Moswin, J. A.	790 Broadway, Gary	Lake
McClelland, Harry N.	New Castle	Henry
McKittrick, W. O.	Washington	Daviess-Martin
P		
Payne, A. C.	2020 Broadway, East Chicago	Lake
Peacock, N. F.	Ben Hur Bldg., Crawfordsville	Montgomery
Peck, Edward A.	422 Conkey St., Hammond	Lake
Pentecost, Paul S.	Charity Hospital, New Orleans, La.	Wayne-Union
Priebe, Fred H.	Ben Hur Bldg., Crawfordsville	Montgomery
Puryear, J. Otway	1606 Broadway, Gary	Lake
R		
Richey, Clifford O.	400 S. Kelsey Ave., Evansville	Vanderburgh
Robertson, William	Spiceland	Henry
S		
Scea, W. A.	Elwood	Madison
Schulze, Hans A.	98 N. Ewing, Indianapolis	Marion
Sears, Don A.	Odon	Daviess-Martin
Stone, C. E.	1416 "I" St., Bedford	Lawrence
Stouder, C. E.	Gosport	Owen-Monroe
T		
Taylor, W. M.	Ben Hur Bldg., Crawfordsville	Montgomery
Tomak, Milton	Linton	Greene
Troutwine, W. R.	224 S. Court St., Crown Point	Lake
V-W-Y		
Vye, J. Preston	607 Broadway, Gary	Lake
Waits, Chester L.	Colfax	Clinton
Washintgon, G. K.	1606 Broadway, Gary	Lake
Young, C. Curtis, Jr.	12 S. E. 7th St., Evansville	Vanderburgh

News Notes

ARMED FORCES INDUCTION OF PHYSICIANS

The Council on National Emergency Medical Service of the American Medical Association has expressed its support of legislation, if necessary, to provide for the military call on a priority schedule of physicians needed for national defense.

The council's recommendation, submitted to the A.M.A. Board of Trustees for approval, placed emphasis on the first call of the nearly 8,000 non-veteran physicians who received training at government expense during and since World War II and of all others who were deferred in order to complete their medical studies.

The recommendation was based on the understanding that an appropriate body be established in government to effect certain measures relative to the utilization of physicians by the medical departments of the Armed Forces.

These measures are:

(1) That the induction of physicians into the Armed Forces be kept to the minimum needed to provide adequate medical service to the personnel of these forces.

(2) That appropriate consideration be given to current and potential needs of the civilian population for medical services.

(3) That in calling civilian physicians, including reserve officers, for military service the following priorities be observed:

(a) Those physicians who were permitted to pursue their medical educations during World War II and who did not serve as medical officers.

(b) Those physicians who were below the Selective Service age during World War II.

(c) Those physicians who graduated prior to World War II but did not serve with the military services during the last war and those physicians who had service as medical officers but entered service subsequent to V-J Day.

(d) Those physicians who served the least time in World II during active hostilities.

(4) That in case of prolonged mobilization some provisions be made for the rotation of physicians between the military services and the civilian population.

James C. Sargent, of Milwaukee, professor of urology at Marquette University School of Medicine, is chairman of the council, of which Roscoe L. Sensenich, of South Bend, is a member.

INDIANA COMMISSION ON CHRONIC ILLNESS

At the dedication of the new Indiana State Board of Health Building in Indianapolis, Governor Henry F. Schricker announced appointment of the following members of the newly organized Indiana Commission on Chronic Illness: **F. R. Nicholas Carter, M.D.**, of South Bend, chairman; **L. E. Burney, M.D.**, Indianapolis; **Donald J. Caseley, M.D.**, Indianapolis; A. L. Harter, D.D.S, of Kokomo; Miss Nellie Brown, of Muncie; Mrs. Meredith Nicholson, Jr., of Indianapolis; Mr. M. O. Hunt, of Indianapolis; and Miss Charlotte Bray, of Monrovia. The purpose of the commission is to study problems pertaining to chronic diseases and make recommendations to the agencies and organizations existing for the purpose of meeting these problems.

BRAYTON FOUNDATION

The Alembert Winthrop Brayton Skin and Cancer Foundation has arranged its Fall Program of 1950. The first meeting will be held on September 28, at Indianapolis General Hospital, when Dr. Francis E. Senear, chairman of the Department of Dermato-Syphilology of the University of Illinois School of Medicine, will preside. A paper selected by Doctor Senear will be presented from 8:30 to 9:30 A.M., in the Lilly Auditorium. Following this, cases will be arranged for viewing in the skin clinic, and from 10:30 until noon a discussion of these cases will be held in the conference room of the Department of Dermato-Syphilology, at Indianapolis General Hospital. Announcement of future meetings will be carried in subsequent issues of THE JOURNAL.

HOUSE FIXES A.M.A. MEMBERSHIP DUES

At the A.M.A. San Francisco meeting of the House of Delegates, the subject of dues for 1951 was considered. The House set the dues for the ensuing year at $25. A subscription to The Journal of the A.M.A. was included in the dues.

Fellowship in the Scientific Assembly was preserved and Fellowship dues were set by the Board of Trustees at $2 per year. Fellows may elect to take a special journal in lieu of The Journal of the A.M.A., which they would ordinarily receive as members. This privilege is not extended to members who are not Fellows of the Scientific Assembly.

OBSTETRICAL AND GYNECOLOGICAL MEETING

The Indianapolis Obstetrical and Gynecological Society will play host to similar organizations from Cincinnati and Louisville on Wednesday, October 18. This will be an all-day meeting, starting at 9:30 a.m. with operative clinics in obstetrics and gynecology at Indianapolis General Hospital. The afternoon session will begin at 2:00 p.m., with "dry clinics," which will include discussions by members of all three societies. This will be held in the auditorium of the medical school.

There will be a dinner meeting at 6:30 p.m. at the Indianapolis Athletic Club, when there will be an outstanding guest speaker. All members are cordially invited to both the day and evening meetings. For further information, contact the secretary of the Indianapolis organization, Dr. Sprague H. Gardiner, 314 Hume Mansur Building, Indianapolis.

INTERNATIONAL COLLEGE OF SURGEONS

The fifteenth annual assembly of the International College of Surgeons (United States Chapter) will be held October 31, November 1, 2 and 3, 1950, at the Cleveland Public Auditorium, Cleveland, Ohio. Dr. George J. Garceau and Dr. Harvey Sigmund, both of Indianapolis, are scheduled to present a paper on "Impacted Fractures of the Anatomical Neck of the Femur," at 2:30 p.m. on November 1. For further information, write to Dr. Arnold S. Jackson, secretary, 1516 Lake Shore Drive, Chicago, Illinois.

The 78th Annual Meeting of the American Public Health Association and meetings of 32 related organizations in the field of public health and preventive medicine will be held in Kiel Auditorium, St. Louis, Missouri, October 30 to November 3.

More than 400 speakers and discussants will participate in the scientific programs under development by the thirteen Sections.

POSTGRADUATE COURSE ON GENERAL MEDICINE

On September 21, 22, and 23 the Frank E. Bunts Institute and the Cleveland Clinic will present a continuation course for physicians on "Practical Problems in General Medicine." Dr. M. A. Blankenhorn, Professor of Medicine at University of Cincinnati, will give the evening address on September 21 on "The Rickettsial Diseases." Inquiries regarding the complete program and registration can be addressed to the Director of Education, Frank E. Bunts Educational Institute, 2020 East Ninety-third Street, Cleveland 6, Ohio.

POSTGRADUATE COURSE ON CANCER

There will be an intensive, two-day postgraduate course on cancer at the Indiana University Medical Center, Wednesday and Thursday, September 20 and 21, presented by the staff of the Indiana University School of Medicine. Enrollment is limited to twenty-five. Registration fee is $25.00. For further information address Recorder's Office, Indiana University School of Medicine, 1040 West Michigan Street, Indianapolis 7.

POSTGRADUATE REFRESHER COURSE FOR THE GENERAL PRACTITIONER

The annual refresher course for the physician in General Practice will be presented by the Indiana University School of Medicine on the medical center campus, Wednesday and Thursday, October 11 and 12. The registration fee is $10.00 per day. Address the Recorder's Office, Indiana University School of Medicine, 1040 West Michigan Street, Indianapolis 7, for further information.

AMERICAN COLLEGE OF PHYSICIANS POSTGRADUATE COURSES

The American College of Physicians has announced its schedule of postgraduate courses for the fall of 1950. These courses will be open to nonmembers with adequate preliminary training.

Course No. 1 will be on internal medicine, September 25 to 30, 1950, at the University of Pittsburgh Medical Center. The fee for nonmembers is $60.00.

Course No. 2 will be on the physiological basis of internal medicine, October 9 to 14, 1950, at Duke University School of Medicine, Durham, N.C. Fee for nonmembers is $60.00.

Notice of subsequent courses will be carried in future issues of THE JOURNAL. For further information, address: Mr. E. R. Loveland, Executive Secretary, American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

Dr. Frederick Allen, of Salem, has moved to New Albany, where he is associated with Dr. Herbert Sloan in the practice of medicine.

Dr. Arthur B. Burnett has opened an office at 310 Burr Building, in New Castle, in association with Dr. Robert A. Smith. Doctor Burnett will limit his practice to ophthalmology. A 1937 graduate of Indiana University, he interned at Indiana University Medical Center, and practiced for four years at the Epileptic Village in New Albany, before entering the service in 1942. During World War II he served with the Army Medical Corps in Africa, Corsica and France, being discharged with the rank of major. Upon his release from service he became clinical director at the Epileptic Village, from 1946 until 1948, when he began a two-year residency in ophthalmology at the Indiana University Medical Center and Indianapolis General Hospital.

AMERICAN HEART ASSOCIATION

Dr. Howard B. Sprague, President of the American Heart Association, announces that new applications for Research Fellowships and Established Investigators will be accepted up to September 15, 1950. Applications for Research Grants-in-Aid, including grants to basic sciences, may be filed up to December 15, 1950.

Information and application forms may be obtained from Dr. Charles A. R. Connor, Medical Director, American Heart Association, 1775 Broadway, New York 19, N. Y.

Dr. Sprague pointed out that 10 percent of the Association's research funds, or approximately $45,000, will be available during the academic year 1951-52 to support research investigations in basic sciences, even though such investigations are not directly related to the field of cardiovascular diseases.

The Arthritis and Rheumatism Foundation is offering fellowships for research in the basic sciences related to the study of arthritis. These fellowships carry a stipend of from $4,000 to $6,000, depending upon the needs and ability of the worker, and run for a period of one year. The fellowships would begin in July, 1951, although earlier appointments would be considered by the committee.

Applications should be sent to the Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, New York, by January 1, 1951. Notification of the fellowships granted will be made March 1, 1951. If any applications are received by September 15, 1950, they will be acted on at that time and notification made immediately.

Dr. Charles W. Cure, who was recently awarded the degree of Doctor of Philosophy in the Department of Surgery of the University of Chicago, has become associated with Drs. E. Vernon Hahn and Paul Merrell at 914 Hume Mansur Building, in Indianapolis. A 1944 graduate of Indiana University School of Medicine, Doctor Cure interned at Minneapolis General Hospital, and took special training in neurological surgery at the Montreal Neurological Institute in Canada.

Dr. Merrell S. Davis of Marion was recently appointed as a member of the Board of Trustees of Indiana University by Governor Schricker.

UROLOGY AWARD

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize of $300, and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

For full particulars write the Secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, New Jersey. Essays must be in his hands before February 10, 1951.

INDIANA HOSPITAL ASSOCIATION WAR EMERGENCY COMMITTEE APPOINTED

To assist in shortening the period and the winning of the war, the Indiana Hospital Association dedicates itself to full cooperation with the United States Government.

Due to the fact that rationing, black outs, and other war problems must be met by Indiana hospitals, a committee has been appointed to represent the hospitals in fulfilling their obligations and responsibilities. The committee is as follows:

J. Milo Anderson Administrator Methodist Hospital Gary Chairman	Miss Olive Murphy Administrator Bartholomew County Hospital Columbus
Dr. Charles M. Myers Administrator Indpls. General Hospital Indianapolis	Sister Lydia Administrator St. Vincent's Hospital Indianapolis
E. C. Moeller Administrator The Lutheran Hospital Fort Wayne	Mrs. Helen M. Boyer Administrator Dunn Memorial Hospital Bedford

Albert G. Hahn, Administrator
Protestant Deaconess Hospital, Evansville

Dr. Everett A. King, of Evansville, has been called to report as a reservist for active duty with the U. S. Marine Corps. He served for four years with the marines during World War II, which included service in the Pacific theater.

Dr. G. H. Kamman, of Seymour, recently celebrated the completion of fifty years of the practice of medicine in that city. He is an honorary member of the Jackson County Medical Society, and served for thirty-five years as secretary of that society. For seventeen years he has served as health officer for Seymour.

Dr. Herbert T. Wagner, a native of Indianapolis, has been appointed director of hospital services for the National Foundation for Infantile Paralysis. Doctor Wagner is a graduate of Indiana University School of Medicine, and served his internship at the Methodist Hospital in Indianapolis. He received a degree in hospital business administration from the University of Chicago. He has served on the medical staff at Culver Military Academy, was a former director of the Meriden (Connecticut) Hospital, was formerly assistant director of Roosevelt Hospital in New York City, and recently resigned as director of the Utah State Hospital for Poliomyelitis at Salt Lake City.

Having recently completed his internship at St. Vincent's Hospital in Indianapolis, Dr. Arthur Wagner has begun the practice of medicine in Vevay.

Dr. W. J. Brockman, a native of Fulda, has opened an office for the practice of medicine in Corydon. A 1949 graduate of the University of Louisville School of Medicine, he interned at Louisville General Hospital.

Dr. Carl Huckleberry, of Danville, has moved to Greencastle, where he is physician in charge at the Indiana State Farm. In addition to those duties, he will open an office in Cloverdale for the general practice of medicine.

Dr. Patrick Hess has established an office in New Albany for the practice of pediatrics. A native of New Albany, he is a 1945 graduate of the University of Louisville School of Medicine, and served his internship at St. Frances Hospital, in Peoria, Illinois. Following this he served in the Army, from 1946 to 1948, at Valley Forge General Hospital. Since his release from service, he was resident pediatrician at St. Joseph's Infirmary in Louisville.

Announcement has been made of the appointment of Dr. Paul R. Lurie as assistant professor of Pediatrics at the Indiana University Medical Center. A graduate of Columbia University College of Physicians and Surgeons, Doctor Luria served an internship in pediatrics at New Haven, Connecticut. Following military service as a squadron surgeon with the Second Air Commandos in India and Burma, he joined the staff of the Yale University School of Medicine, and for the past two years he was a public health research fellow of the National Heart Institute.

Dr. Ward Laramore, who has been practicing in LaPorte, has returned to serve with the Veterans Administration at Billings Hospital at Fort Benjamin Harrison, in Indianapolis. He had engaged in the practice of internal medicine and cardiology at Billings Hospital before going to LaPorte to practice.

Announcement was made recently by Dr. Clarence R. McIntire of the opening of an office for the practice of internal medicine at 3202 North Meridian Street, in Indianapolis.

Dr. Richard Potter, of Oak Ridge, Tennessee, recently became associated in the practice of medicine with Dr. Arvin Henderson at Ridgeville. Doctor Potter is a graduate of the University of South Carolina School of Medicine, and interned at the St. Francis Hospital at Charleston, South Carolina, and at the Oak Ridge Hospital.

Dr. Fred H. Priebe recently opened an office for the general practice of medicine in Crawfordsville. Following his graduation from the University of Cincinnati School of Medicine, he interned at Indianapolis General Hospital, then took two additional years of training in neuropsychiatry at the Veterans Hospital at Marion, and two years of training in internal medicine at the Cold Springs Veterans Hospital at Indianapolis. Doctor Priebe is a veteran of World War II.

Dr. Robert J. Schwarz, a graduate of the University of Colorado School of Medicine, is establishing a practice in Acton.

Dr. David J. Smith has announced the opening of an office at 910 Hume Mansur Building, in Indianapolis, for the practice of general surgery. Doctor Smith served in the Army for thirty months during World War II, and was in Europe with the 89th Infantry Division. He was discharged with the rank of major. A 1942 graduate of Indiana University School of Medicine, he served his internship at the Methodist Hospital in Indianapolis, where he also took three years of postgraduate work.

Deaths

Captain Robert Martin Moore, Jr., was the first Korean war fatality from Indianapolis. The son of Dr. Robert M. Moore, of Indianapolis, the junior Doctor Moore was serving as medical officer with the 24th Infantry Division Artillery in Korea, when he was killed in action on July 16. He was twenty-nine years old. He was a graduate of the University of Cincinnati College of Medicine in 1946, and interned at Indianapolis General Hospital. He was called to active duty three years ago, and served at McCornack General Hospital at Pasadena, California, and at Letterman General Hospital in San Francisco.

Arthur J. Kelsey, M.D., of Monterey, died suddenly on July 25 at his home. He was sixty-nine years old. He was a graduate of the Rush Medical College, in Chicago, in 1903, and was a member of the Pulaski County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Clyde C. Morrison, M.D., of Greensburg, Honorary member of the Decatur County Medical Society and the Indiana State Medical Association, died on August 8, after an illness of two months. He was a 1903 graduate of the Grand Rapids, Michigan, Medical College, and was a Fellow of the American Medical Association.

Earl Stimson Niblack, M.D., for fifty years active in medical practice at Terre Haute, died on July 14 in Manhasset, New York, at the age of eighty. He graduated from the University of Michigan Medical School in 1895, and was an honorary member of the Vigo County Medical Society since his retirement in 1947. He also was a member of the Indiana State Medical Association and of the American Medical Association.

Wendell A. Preston, M.D., age thirty-nine, died on July 14 at his home in Angola. He was retired after duty with the United States Public Health Service, as a lieutenant commander in the Coast Guard, stationed in the Aleutian Islands during World War II, and his death terminated a long illness. He had graduated from Indiana University School of Medicine in 1937 and was a Fellow of the American Medical Association.

David W. Fosler, M.D., age sixty-eight, died on July 14, in Indianapolis. He was a graduate of the Medical College of Indiana at Indianapolis in 1905, and had practiced medicine for forty-five years, specializing in surgery. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

Benjamin A. Speheger, M.D., of Bedford, died on July 24, at the age of forty-one. He was a graduate of Indiana University School of Medicine in 1938, and had practiced in Bedford since 1939. Doctor Speheger was a member of the Lawrence County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Herbert Y. Mullin, M.D., of Rockfield, died on July 20, at the age of seventy-three. He had practiced medicine in Rockfield for forty-five years. A 1904 graduate of the Illinois Medical College, in Chicago, Doctor Mullin was a member of the Carroll County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

July 16, 1950

The Council of the Indiana State Medical Association convened for its summer meeting at 10:20 a.m., daylight saving time, Sunday, July 16, 1950, in Parlor B, Claypool Hotel, Indianapolis, with Dr. W. U. Kennedy, chairman, presiding. Roll call showed the following present:

Councilors:

First District____Paul D. Crimm, Evansville, alternate
Second District_____William C. Reed, Bloomington
Third District_____William H. Garner, New Albany
Fourth District_____George A. May, Madison
Fifth District_____A. M. Mitchell, Terre Haute
Sixth District_____W. U. Kennedy, New Castle
Seventh District_____Roy A. Geider, Indianapolis
Eighth District_____E. H. Clauser, Muncie; T. R. Hayes, Muncie, alternate
Ninth District_____Wemple Dodds, Crawfordsville; Harry E. Klepinger, Lafayette, alternate
Tenth District_____W. H. Howard, Hammond
Eleventh District_____Elton R. Clarke, Kokomo
Twelfth District_____M. B. Catlett, Fort Wayne
Thirteenth District___G. O. Larson, LaPorte, alternate

Officers:

Alfred Ellison, South Bend, president-elect
Frank B. Ramsey, Indianapolis, editor of THE JOURNAL
W. L. Portteus, Franklin, chairman, Executive Committee
C. J. Clark, Indianapolis, member, Executive Committee

Guests:

F. S. Crockett, LaFayette, delegate to A.M.A.
W. M. Cockrum, Evansville, delegate to A.M.A. and co-chairman, Committee on Convention Arrangements
C. E. Boyd, West Baden Springs, co-chairman, Committee on Convention Arrangements
Cleon A. Nafe, Indianapolis, alternate delegate to A.M.A. and chairman, Indiana A.M.A. Campaign Coordinating Committee
J. William Wright, Indianapolis; Don E. Wood, Indianapolis, co-chairmen, Legislative Committee
Norman R. Booher, Indianapolis, chairman, Technician Training Study Committee
Joseph L. Haymond, Indianapolis, president; Lall G. Montgomery, Muncie, secretary, Indiana Association of Pathologists
Albert Stump, Indianapolis, attorney
Glen Ward Lee, Richmond, chairman, Committee on Veterans Affairs and Rehabilitation

On motion of Doctor Mitchell, duly seconded, the minutes of the April 16, 1950, meeting of the Council, held at Indianapolis, were approved as printed in the June, 1950, issue of THE JOURNAL.

Unfinished Business

1. *Matters referred to Council by Executive Committee.* Doctor Portteus presented the following matters for consideration of the Council:

a. *Indiana memberships in A.M.A.* On motion of Drs. Mitchell and Catlett, the Council approved the recommendation of the Executive Committee that a bulletin be prepared which will familiarize the various county medical societies and the councilors with all of the rules concerning payment of A.M.A. dues. Also, the field secretary's services are to be utilized to bring about a better understanding of this matter with the physicians of the state. This action was prompted by the fact that to date only 2,129 Indiana members have paid 1950 A.M.A. dues.

b. *Resolution concerning the Hess report.* On motion of Drs. May and Dodds, the Council adopted the following resolution which had been approved by the Executive Committee with the recommendation that it be submitted to the Council for adoption:

RESOLUTION

WHEREAS: The "Hess" committee made a report to the House of Delegates of the American Medical Association in June, 1949, in Atlantic City regarding the practice of medicine by hospitals or other corporations, and

WHEREAS: The "Hess" report states, "therefore, hospitals and medical schools cannot charge patients fees for medical services rendered by physicians even though the physicians are full time employees of an individual or institution," and

WHEREAS: The "Hess" report was adopted by the American Medical Association House of Delegates, and instructions were given to the Trustees of the American Medical Association to enforce the matters and principles contained in the report, and

WHEREAS: The House of Delegates of the American Medical Association in December, 1949, convened in Washington, D. C., again confirmed the principles contained in the "Hess" report and directed that action by the Trustees deriving from this report be delayed only until legal requirements were investigated and met so that all actions taken would comply with the law, and

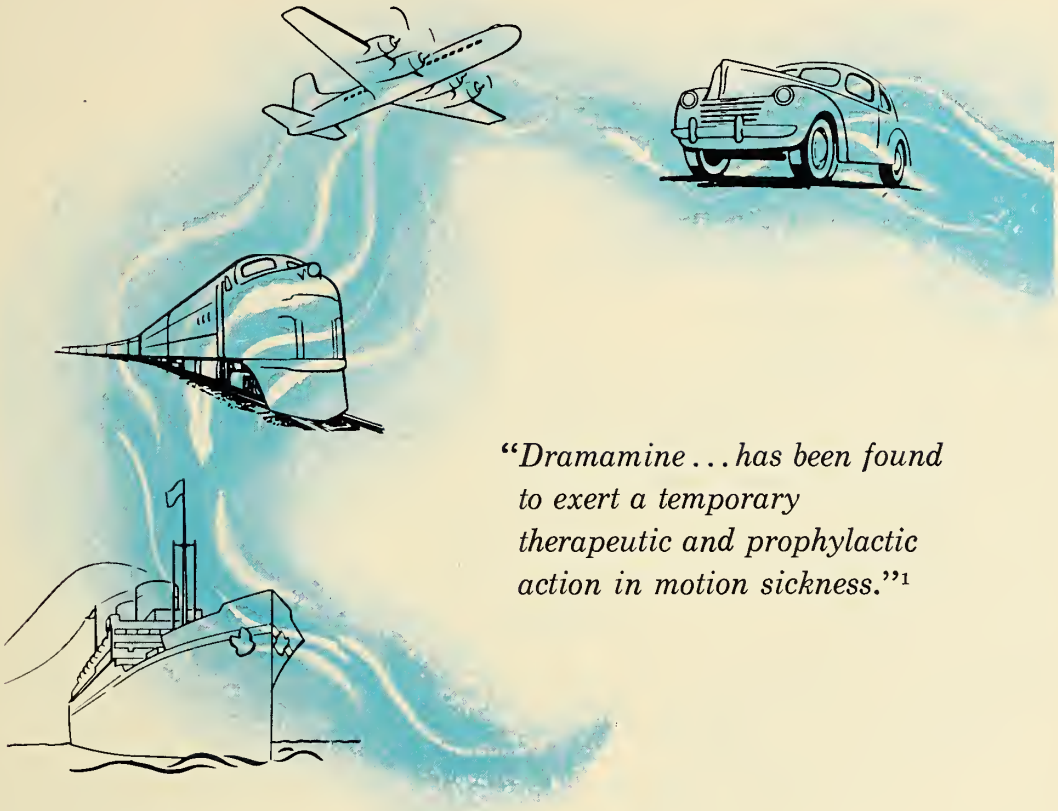
WHEREAS: The "Hess" committee is to report its further study to the House of Delegates in San Francisco in June, 1950, and likewise the Trustees of the American Medical Association are to report at this convention, and

WHEREAS: It is apparent to the physicians of Indiana that since the position of medical practitioners in the fields of anesthesiology, pathology and roentgenology has been subjugated by many hospitals and other corporations, the attitude and ambitions of such officials will logically lead to the same subjugation of other physicians practicing in other special fields of medicine, and

WHEREAS: This subjugation of the aforementioned specialists serves to discourage high quality individuals from entering these specialties in adequate numbers, and

WHEREAS: These aforementioned basic medical services, if rendered on a high plane, constitute the keystone of good medical service in a community, and

WHEREAS: In America there is developing, even among some physicians in local authority, the philosophy that groups of physicians may ethically band together to employ and subjugate fellow physicians, which is beneath the dignity of professional practice,



"Dramamine . . . has been found to exert a temporary therapeutic and prophylactic action in motion sickness."[1]

Dramamine

for the Prevention or Treatment of Motion Sickness

Unusually satisfactory results have been obtained with Dramamine* (brand of dimenhydrinate) as a prophylactic or active therapeutic agent for the relief of nausea, vomiting or dizziness, which many individuals experience in travelling by ship, airplane, train and other vehicles.

1. Council on Pharmacy & Chemistry: New and Nonofficial Remedies, 1950, Philadelphia, J. B. Lippincott Co., 1950, p. 460.

*Trademark of G. D. Searle & Co., Chicago 80, Ill.

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Therefore, Be It Resolved: The House of Delegates of the Indiana State Medical Association affirms the principles enunciated in the "Hess" report, and

Be It Further Resolved: The House of Delegates of the Indiana State Medical Association requests the House of Delegates of the American Medical Association to delay no longer in accomplishing the enforcement of Section 6, Article VI, Chapter III of the Principles of Medical Ethics, and

Be It Further Resolved: That the House of Delegates of the American Medical Association take cognizance of the fact that while the physicians of America are opposing their subjugation by the present Federal Government we are witnessing the subjugation of certain segments of our own profession, instituted or condoned by other members of our profession.

c. *Additional appropriation of funds to Indiana A.M.A. Campaign Coordinating Committee.* Recommendation of the Executive Committee (Budget Committee) that an additional appropriation of $30,000 be allowed the Indiana A.M.A. Campaign Coordinating Committee for the purpose of continuing the newspaper advertising program and employing whatever other mediums may be necessary to carry on the educational campaign was approved by the Council, on motion of Drs. Catlett and Mitchell.

d. *Report of Committee to Study Training of Girls to Do Simple Laboratory Procedures.* On motion of Drs. Dodds and Reed, the Council adopted the report of the Committee to Study Training of Girls to Do Simple Laboratory Procedures, as published in the June, 1950, issue of THE JOURNAL, which includes the minutes of the December 11, 1949, and January 29, 1950, meetings of the committee and contains the following five major recommendations:

(1) That the Indiana State Medical Association ask the legislature, at its next session, to make funds available to increase facilities at Indiana University for training of fully qualified laboratory workers.

(2) That the Indiana State Medical Association formulate plans to facilitate recruitment and placement of prospective student medical laboratory workers in approved training schools, and that more hospitals be asked to establish approved schools for the training of medical laboratory workers.

(3) That the Council on Medical Education and Hospitals of the American Medical Association be requested to call a conference of all interested organizations and agencies and that these agencies be asked to increase the facilities for training qualified medical laboratory workers, with the objective of increasing the number of these workers to fill the great national needs.

(4) That the Council on Medical Education and Hospitals of the American Medical Association be further requested to make adequate provision for immediately supplying laboratory workers for medical practitioners' offices, and that this be given the most urgent attention.

(5) That the Executive Committee of the Indiana State Medical Association survey the present use of medical laboratory workers in physicians' offices.

e. *Contract with Veterans Administration.* Doctor Lee, chairman of the Committee on Veterans Affairs and Rehabilitation, explained that the new contract with the Veterans Administration for the year beginning July 1, 1950, is the same contract that has been in force, with the exception of the following three amendments which were proposed by his committee, in order to facilitate payments to participating physicians:

(1) Addition of a combination item of Blood Typing and Cross Matching at a recommended fee of $5. The Veterans Administration has approved a fee of $3 for this service.

(2) Addition of Blood Thiocyanate level determination at a fee of $2, which was approved by the Veterans Administration.

(3) Amendment to paragraph 2 of Note in Part II, page 5, as follows (amendments in italics), in order to insure payment to general practitioners for multiple services rendered in a single office call or home visit and eliminating the necessity of the Regional VA office placing a detailed report of circumstances on such bills before they could be paid:

"If two or more surgical *or medical procedures* are performed by the same physician on the same patient concurrently or immediately successively, (e.g., repair of unilateral indirect inguinal hernia and operation for varicocele; *or, office, hospital or home visit plus injections, intravenous medication or other medical services*) the fee for two or more procedures will be the greater or greatest fee plus one-half each smaller fee or fees. The fee for two or more such concurrent operations *or medical call and special treatment* will never exceed twice the greater or greatest fee."

This amendment was rejected by the Veterans Administration. However, this will not affect the individual physicians as VA has issued directives to participating physicians as to proper preparation of their bills and it will add endorsements where necessary so that prompt and proper payments will be made.

Other changes made by the Veterans Administration follow:

(1) Paragraph 5(c), reading as follows, to be deleted:

"It is further understood that services of physicians hereunder will be so utilized that fees therefor to any individual physician will not exceed $6,000 per annum without the prior approval of the Chief Medical Director, Veterans Administration, Washington, D.C. It will be the responsibility of the Veterans Administration to enforce this policy and to advise all participating physicians that it is in effect. All Veterans Administration Branch Medical Directors have been instructed with regard to this policy."

(2) The following additional paragraph to be included in the contract:

"16. Except as otherwise specifically provided in this contract, all disputes concerning question of fact arising under this contract shall be decided by the contracting officer, subject to written appeal by the contractor within thirty (30) days to the head of the department concerned or his duly authorized representatives, whose decision shall be final and conclusive upon the parties hereto."

On recommendation of Doctor Lee and the Committee on Veterans Affairs, the Council approved the new contract with the Veterans Administration, on motion of Drs. Howard and Geider.

A Real American Breakfast

That a nutritious breakfast providing generous amounts of high quality protein prevents late morning hypoglycemia has been amply demonstrated. As shown by Thorn and co-workers,[1] and later confirmed by Orent-Keiles,[2] ". . . breakfast high in protein and low in fat and carbohydrate was followed by an improved sense of well-being and no symptoms of hypoglycemia."

Meat for breakfast—ham, sausage, bacon, breakfast steaks—is an appetizing means of increasing the protein content of the morning meal. Its biologically complete protein contains all essential amino acids, and serves well in complementing less complete proteins from other sources. Furthermore, muscle meat is an outstanding source of B complex vitamins and of iron.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., Ann. Int. Med. 18:913 (June) 1943.
(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

American Meat Institute
Main Office, Chicago . . . Members Throughout the United States

f. *Civilian Defense program.* Doctor Portteus urged the councilors to consider the question of civilian defense in their respective districts and to do everything possible to get this situation in hand.

Doctor Lee reported that a letter from Paul J. Larsen, director of Civilian Mobilization Office for the National Security Resources Board, recommends to the Governor that he designate the State Health Officer as the person responsible for state civil defense health services. It further recommends that local civil defense agencies be encouraged to appoint their local health officer to head their civil defense health and medical services. Doctor Lee said, "I have suggested to the Executive Committee that an organization along such political lines might not produce the maximum cooperation from the medical profession and might interfere with local plans already in existence in many localities. Officers of county medical societies or their designated representative should be the persons responsible for delegation of assignment and duties of civilian physicians. The Executive Committee directed me to work with Doctor Burney to organize the most efficient utilization of our state and county medical societies in the civil defense program."

On motion of Drs. Mitchell and Howard, the Council authorized Doctor Lee and the Committee on Veterans Affairs to cooperate in the setting up of an efficient civilian defense program without necessarily following the suggestion of the National Security Resources Board.

2. *Report of Indiana A.M.A. Campaign Coordinating Committee.* Doctor Nafe, chairman, reported on the activities of the Indiana A.M.A. Campaign Coordinating Committee to date and asked for a clarification by the Council as to whether or not his committee should spend the additional appropriation of $30,000 or should this money be only available in case it is needed. It was taken by consent that this additional appropriation should be used at the discretion of the members of the A.M.A. Coordinating Committee.

3. *Nominations for Editorial Board.* Doctor Mitchell nominated Dr. Thomas M. Conley, Kokomo (general practice). Dr. Clyde G. Culbertson, Indianapolis (research), was nominated at a previous meeting.

4. *Report of Special Committee on Disability Insurance.* Each councilor had been supplied prior to the meeting with a copy of a report from this committee in which the committee recommended that it, or a similarly constituted committee, be continued for the purpose of further conferences and study. It was taken by consent that the committee be continued and that it report its recommendations at a future meeting of the Council.

5. *Retirement income plan.* Doctor Clarke, chairman of the Study Committee on Retirement Income Plan, reported that copies of the proposal of the Jefferson National Life Insurance Company had been sent to each councilor since the April 16 meeting of the Council. He reported further that the Study Committee on Retirement Income Plan recommends the adoption of the plan submitted by the Jefferson National Life Insurance Company of Indianapolis. Doctor Clarke moved that the Jefferson National Life Insurance Company's plan, known as the Independence Plan, be adopted. The motion was seconded by Dr. E. H. Clauser, and was carried unanimously.

6. *Matters to be referred to House of Delegates.*

a. On motion of Drs. Catlett and Howard, the following amendment to Chapter XI, Section 12, of the By-laws, which was approved by the Council at the April 16, 1950, meeting, is to be referred to the Committee on Constitution and By-laws for presentation to the House of Delegates at the French Lick session:

> "In the event the county society remits a member's dues for good cause and the secretary of a county medical society recommends in writing the remission of the state dues of said member of the society, and shows good cause why such recommendation should be granted, the Council shall have the power to remit said dues."

b. On motion of Drs. Howard and May, the following resolution, which was adopted February 5, 1950, by the Lake County Medical Society Council, was approved by the Council and is to be referred to the Committee on Constitution and By-laws for presentation to the House of Delegates at French Lick:

> WHEREAS the United States of America is today confronted with grave threats to its security from both within and without its borders; and,
>
> WHEREAS many persons within the country who profess friendship for this country do, in reality, support the views of unfriendly nations; and,
>
> WHEREAS one of the subterfuges is professed citizenship in the United States, which citizenship does not, in fact, exist;
>
> *Now Therefore Be It Resolved* that the House of Delegates of the Indiana State Medical Association amend its qualifications for membership to include as a prerequisite for that membership evidence of citizenship in the United States of America or attainment of first papers toward such citizenship.

1950 (101st) Annual Session at French Lick

Drs. Boyd and Cockrum, co-chairmen of the Convention Arrangements Committee, reported briefly on entertainment plans for the French Lick session.

Legislative Matters

Doctor Clarke introduced the following resolution, which the Council adopted on motion of Drs. Clarke and May, for submission to the Indiana State legislature:

> Resolution memorializing the Congress of the United States with respect to a national compulsory sickness insurance program:
>
> WHEREAS the American people now enjoy the highest level of health, the best standards of scientific medical care and the finest medical institutions ever attained by any major country in the world; and
>
> WHEREAS these accomplishments of American medicine are the results of a free profession, working under a system of free enterprise; and

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Would you appreciate ease and certainty in infant feeding?

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3. Two added sugars—lactose and dextrose.
4. Full requirements of Vitamins A and B_1.
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Dear Sirs:

Please let me tell you how much I like your product. When my son was born I dreaded the daily task of measuring and cleaning all the utensils necessary in formula making. Then my doctor advised me to use Baker's Milk. I can't tell the joy I had when he told me to use half and half.

But now as I watch the little one growing I am convinced Baker's is all the doctor said and more. More people comment on the baby's complexion and growth.

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Very truly yours,

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ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

WHEREAS the experience of all countries where government has assumed control of medical care has been a progressive deterioration of medical standards and medical care, to the detriment of the health of the people; now, therefore, be it

Resolved by the members of the Indiana Legislature in eighty-seventh session assembled, a majority of the members agreeing thereto:

1. That the Legislature of the state of Indiana respectfully request the Congress of the United States to refrain from imposing upon the citizens of the nation any form of compulsory insurance, or any system of medical care designed for national bureaucratic control.

2. That Indiana Senators and Representatives now in the Congress of the United States be and are hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation.

3. That copies of this resolution be transmitted by the Clerk of this Legislature to the President of the United States, the presiding officers of the United States Senate and United States House of Representatives, and to each Senator and Congressman from Indiana.

New Business

1. *Election of assistant treasurer.* Dr. Roy V. Myers of Indianapolis was elected assistant treasurer of the association.

The Council ruled that, (1) the term of office of the assistant treasurer shall coincide with that of the treasurer, that is, from one annual convention to the next annual convention; and (2) the duties of the assistant treasurer shall be to perform the duties of the treasurer in the absence for any reason, or the inability of the treasurer to perform his regular duties, and also to assist the treasurer at the treasurer's request in the performance of the duties of the office of treasurer.

2. *Invitation from Indianapolis Medical Society to share quarters in its new home at 2902 N. Meridian Street, Indianapolis.* On motion of Drs. Mitchell and Crimm a special committee of the Council is to be appointed to consider this proposal and this committee is to report to the Council at its January 1951 meeting. (The chairman appointed Doctor Mitchell, chairman, and Drs. Reed and Garner members of this special committee.)

3. *Rural Health Conference.* Doctor Crockett extended an invitation to the members of the Council to attend the Conference of County Rural Health Councils to be held at Purdue University on August 1 under the sponsorship of the Rural Health Committee of the Indiana State Medical Association and the Agricultural Extension Service of Purdue University.

At this time the chairman introduced Dr. Elmer L. Henderson, Louisville, president of the American Medical Association.

DR. HENDERSON: I wish to assure you that it is a real pleasure for me to be with you today. It is always nice to come to Indiana. You have one of the most aggressive state associations in the country. You have always done things up here and I have always admired you. I just wanted to greet you and that's all.

There being no further business, the Council adjourned to meet again at 11:00 a.m., Monday, September 25, 1950, at the French Lick Springs Hotel.

EXECUTIVE COMMITTEE

July 15, 1950

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; Alfred Ellison, M.D.; W. U. Kennedy, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Guest: Glen Ward Lee, M.D., chairman, Committee on Veterans Affairs and Rehabilitation.

Membership Report

Number of members July 10, 1950	3,601*
Number of members July 10, 1949	3,684
Loss over last year	83
Number of members December 31, 1949	3,758
Number who have paid A.M.A. dues	2,129

* Includes 21 in military service; 138 $10.00 members; 208 senior members.

It was taken by consent that the chairman of the Executive Committee should report to the Council the status of Indiana membership in the A.M.A., pointing out that unless approximately 850 more Indiana physicians pay 1950 A.M.A. dues, Indiana will lose one A.MA. delegate. It was suggested that the Council take some steps to encourage more physicians to join the A.M.A.

Legislative Matters

The executive secretary was directed to continue his activity in the Indiana Community Health Committee which is working for full-time local health units throughout Indiana.

Statements of receipts and expenditures for May and June for the association and THE JOURNAL were approved.

1950 Annual Session, French Lick, September 25, 26 and 27, 1950

Badges. Selection of suitable badges was delegated to the executive secretary, on motion of Drs. Ellison and Clark.

A.M.A. Campaign Coordinating Committee

The field secretary reported on the activities of the A.M.A. Campaign Coordinating Committee.

Organization Matters

(1) *Contract with VA.* On motion of Drs. Kennedy and Clark, the Executive Committee directed the Committee on Veterans Affairs and Rehabilitation, of which Dr. Glen Ward Lee is chairman, to sign the contract with the Veterans Administration for the fiscal year ending June 30, 1951, including the changes as agreed upon.

(2) Doctor Clark, chairman of the Committee on Medical and Nursing School Scholarships, reported that the recipient of a medical school scholarship, who completed his internship in June, was repaying the money advanced to him, with interest, in preference to setting up practice in some rural community.

(3) *Conference with Woman's Auxiliary.* Sunday, August 6, was set as the date for a conference

For Safe Symptomatic Relief During the "*Late*" Hay Fever Season

There are good reasons why many allergists consider "late" hay fever a more serious threat than the Spring and Summer types of seasonal allergy: ragweed pollens cause a greater incidence of hay fever than all other pollens combined; more pollens are in the air during the ragweed season than at any other time; and since "the United States is the favorite habitat of ragweed, it has the dubious distinction of harboring more hay fever victims than all the rest of the world together."[1]

Fortunately, more and more patients each year are enjoying the therapeutic benefits of Neo-Antergan® Maleate. Because of its safe and strikingly effective action in relieving the distressing symptoms of allergy, Neo-Antergan has become a favorite antihistaminic with physicians and patients—*in every season of the year.*

Neo-Antergan is advertised exclusively to the medical profession. Your patients can secure its benefits *only through your prescription.*

Neo-Antergan Maleate is stocked by your local pharmacy in 25 mg. and 50 mg. tablets. Complete information concerning its clinical use will be sent on request.

[1]Cooke, R. A.: *Allergy in Theory and Practice.* Philadelphia: W. B. Saunders Company, 1947, p. 186

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COUNCIL ACCEPTED

with leaders of the Woman's Auxiliary to discuss the 1950-51 Woman's Auxiliary program. The meeting is to begin at 10:00 a.m. in the Columbia Club, Indianapolis.

(4) *Blood pressure readings at State Fair.* The committee, by consent, gave the State Fair Committee permission to continue the taking of blood pressure readings at the 1950 Indiana State Fair.

(5) *Hoosier State Press Association membership.* On motion of Drs. Ellison and Clark, the committee authorized continuation of associate membership in the Hoosier State Press Association.

(6) A resolution adopted by the National Association of Boards of Pharmacy, protesting the establishment of physician-owned clinic pharmacies, was read.

(7) Consent was given for the executive secretary to serve as a member of the Joint Citizen's Committee of Indiana on Health and Welfare Legislation.

(8) On motion of Drs. Clark and Kennedy, a 1950 membership in the Indiana State Conference on Social Work, Inc., at $10 was authorized.

(9) The annual report of the Executive Committee to the House of Delegates was read and approved.

(10) *Hess report.* A resolution, prepared by the president-elect, placing the association on record as approving the principles of the Hess report which was presented to the A.M.A. House of Delegates at San Francisco by the delegates from the Indiana State Medical Association, was approved on motion of Drs. Clark and Kennedy. The motion included the recommendation to the Council that it adopt the resolution.

Civilian Defense Program

On motion of Drs. Clark and Kennedy, the chairman of the Committee on Veterans Affairs and Rehabilitation was instructed to confer with the State Health Administrator in working out a plan for a medical civil defense program through the county medical societies, and the chairman was notified to report the outcome of the conference at the next meeting of the Executive Committee.

The Journal

Total advertising in June issue	$2,247.53
Total advertising in July issue	2,564.80

On motion of Drs. Clark and Ellison, the committee recommended the publishing in the convention issue photographs of all physicians appearing on the scientific program at French Lick, including those participating in the panel discussions.

There being no further business, the Executive Committee adjourned to meet again at 10:00 a.m., Sunday, August 27, 1950.

COMMITTEE ON PUBLICITY

June 2, 1950

Present: Marlow W. Manion, M.D., chairman; Homer G. Hamer, M.D.; James O. Ritchey, M.D.; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of July 17, 1950—"Take a Vacation"
Week of July 24, 1950—"Death on Highways"
Week of July 31, 1950—"Hay Fever"
Week of August 7, 1950—"Rabies"
Week of August 14, 1950—"Measles"

July 14, 1950

Present: Marlow Manion, M.D., chairman; James O. Ritchey, M.D.; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of August 21, 1950—"Swat the Fly"
Week of August 28, 1950—"Child Accidents"
Week of September 4, 1950—"Safer Automobiles"

The committee's report of the year's activities, addressed to the House of Delegates of the Indiana State Medical Association, was read and approved.

LOCAL SOCIETY REPORTS

Clay County Medical Society members met at the Elks Home in Brazil on July 11. Six members and three guests were present. Dr. L. L. Blum of Terre Haute discussed laboratory procedures.

Another meeting was held on August 8. This was a business meeting and seven members were present.

LaPorte County Medical Society members met at the Trail Inn in Michigan City on April 20. The guest speaker was Dr. Chester Coggeshall, of Chicago, whose subject was "Certain Aspects of Diabetes." Thirty members were present.

Another meeting was held in LaPorte on May 18, when Dr. Fremont A. Chandler, of Chicago, spoke on "Low Back Pain and Herniated Disks." Thirty-four members attended this meeting.

Posey County Medical Society members held a meeting at New Harmony on July 25. Seven members were present. A legislative committee was appointed, consisting of Dr. J. W. Herr, of Mount Vernon, chairman, Dr. F. W. Oliphant, of Mount Vernon, and Dr. Harold Ropp, of New Harmony.

Putnam County Medical Society members met at the Putnam County Hospital in Greencastle on June 9. Seventeen members were present to hear Dr. Sprague Gardiner, of Indianapolis, speak on "The Management of the Menopause, and Management of Sterility in Women."

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FOR safety and reliability use composite Radon seeds in your cases requiring interstitial radiation. The Composite Radon Seed is the only type of metal Radon Seed having smooth, round, non-cutting ends. In this type of seed, illustrated here highly magnified, Radon is under gas-tight, leak-proof seal. Composite Platinum (or Gold) Radon Seeds and loading-slot instruments for their implantation are available to you exclusively through us. Inquire and order by mail, or preferably by telegraph, reversing charges.

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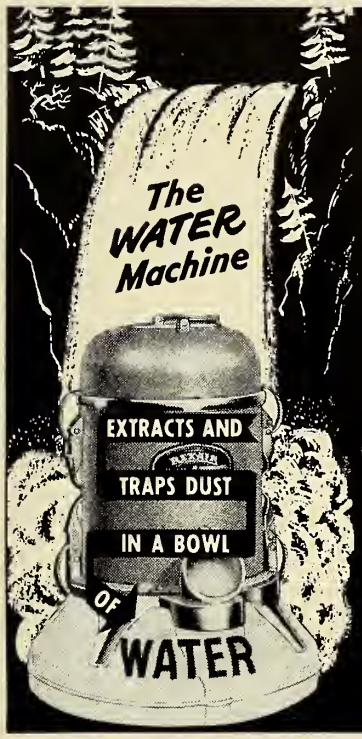

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Water is the secret of Rexair's dust-filtering action. Rexair—and only Rexair—passes the stream of dust-filled air completely through a churning bath of water, discharging clean, humidified air into the room. Rexair direct factory sales and service branches are listed in phone books of principal cities of United States and Canada. Call your local branch or write direct to:

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Aimed and tuned to the requirements of the Cardiovascular patients

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Cardiovascular therapy
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AMINOPHYLLINE
For coronary dilatation and diuretic action.

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For sustained palliative reduction of arterial hypertension without nausea, headache or other side-effects.

RUTIN
For strengthening capillary resistance and avoiding vascular accidents associated with increased capillary fragility.

PHENOBARBITAL
For providing mild sedative to allay apprehension and give much needed rest to the patient.

Each tablet contains:

Aminophylline	50 mg.
Phenobarbital	16 mg.
Rutin	20 mg.
Mannitol Hexanitrate	16 mg.

The degenerative chain reaction of hypertensive disease must be attacked and severed at as many points as are vulnerable to the medical armamentarium. HEXARUTAN—Kendall combines the sound pharmacodynamic actions of four clinically effective drugs to alleviate, fortify and protect the patient in the essential physiologic mechanisms.

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Provides
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THE CARDINAL REQUISITES IN AN AGENT TO AID IN THE CORRECTION OF OBESITY

DL—DESOXYEPHEDRINE
An aid in curbing appetite—imparts feeling of well-being—induces patient cooperation.

THYROID
In mild dosage to stimulate metabolism.

VITAMIN B-COMPLEX WITH ASCORBIC ACID
Essential vitamin fortification for patients on restricted diets.

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WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. D. E. Lybrook, Galveston.
President-elect—Mrs. F. M. Fargher, Michigan City.
Corresponding Secretary—Mrs. E. W. Bailey, Logansport.
Recording Secretary—Mrs. H. P. Sloan, New Albany.
Treasurer—Mrs. Robert Bolin, Elkhart.
Publicity—Mrs. F. M. Gastineau, Indianapolis.

Indiana was honored during the twenty-seventh annual session of the Woman's Auxiliary to the American Medical Association, held in San Francisco during June of this year. Mrs. Frank M. Gastineau, wife of Dr. Frank M. Gastineau, Indianapolis, was named a Director for a term of two years. Mrs. Gastineau has been active in Auxiliary affairs, having served as President of the Indianapolis and Indiana Auxiliaries. During the year 1949, she served as Program Chairman of the State Auxiliary and assisted with the organization work.

Closing with an elaborate reception and ball honoring the President of the American Medical Association, those in attendance hailed the meeting as one of the best in the history of the Auxiliary. Many others viewed it as one of the busiest conventions ever held.

In an exotic atmosphere, in which the decorations, the refreshments and food were all imported from Hawaii, as well as the favors of orchid leis for the ladies, the Auxiliary entertained royally. Their party was attended by an overflowing crowd and lasted until the early hours of the morning, but everyone was enthusiastic in their praise of the reception.

Mrs. Arthur A. Herold, of Shreveport, La., was elevated to the Presidency for the year 1950-51 and Mrs. Harold F. Wahlquist of Minneapolis, Minn., was elevated from first Vice-president to the office of President-elect.

Members of the Indiana Auxiliary serving on committees of the Woman's Auxiliary to the American Medical Association during the year were: Mrs. Truman E. Caylor, Bluffton, Nominating; Mrs. Doran Hogle, Lafayette, *Hygeia;* Mrs. A. W. Ratcliffe, Evansville, Legislation; Mrs. W. R. Morrison, Kokomo, Organization.

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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

A TEXTBOOK OF GYNECOLOGY. By Arthur Hale Curtis, M.D., emeritus professor and chairman of the Department of Obstetrics and Gynecology, Northwestern University Medical School; and John William Huffman, M.D., associate professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago. Sixth edition. 799 pages with 466 illustrations, including 37 in color. Price $10.00. W. B. Saunders Company, West Washington Square, Philadelphia, Pa., 1950.

MEDICAL DIAGNOSIS—Applied Physical Diagnosis. Edited by Roscoe L. Pullen, M.D., professor of Graduate Medicine, director of the Division of Graduate Medicine, and vice dean of the School of Medicine, Tulane University of Louisiana. Second edition. 1119 pages with 601 figures, 48 in color. Price $12.50. W. B. Saunders Company, West Washington Square, Philadelphia, Pa., 1950.

TECHNIQUES IN BRITISH SURGERY. Edited by Rodney Maingot, FRCS. 734 pages with 473 figures. Price $15.00. W. B. Saunders Company, West Washington Square, Philadelphia, Pa., 1950.

PLASTIC AND RECONSTRUCTIVE SURGERY — A Manual of Management. By Ferris Smith, M.D., consultant in Plastic Surgery, Blodgett Memorial Hospital, Grand Rapids, Michigan. 895 pages with 592 figures. Price $15.00. W. B. Saunders Company, West Washington Square, Philadelphia, Pa., 1950.

LET'S NAME THE BABY. 750 first names of boys and girls, giving their meanings and original derivations, plus horoscopes and birthstones. 32 page booklet. 9c each in lots of 1,000; 12½c each in 100; 25c per copy. Juvenile Merchandising, 114 East 32nd St., New York 16, N. Y., 1950.

PRACTICAL GYNECOLOGY. By Walter J. Reich, M.D., attending gynecologist Cook County Graduate School of Medicine; and Mitchell J. Nechtow, M.D., associate attending gynecologist, Cook County Hospital. 449 pages with 187 illustrations, including 55 in color. Price $10.00. J. B. Lippincott Company, East Washington Square, Philadelphia, Pa., 1950.

HANDBOOK OF PHYSIOLOGY AND BIOCHEMISTRY. 40th, Centenary Edition. By R. J. S. McDowall, M.D., professor of physiology, University of London, King's College. 767 pages, with 315 illustrations. Price $7.00. The Blakiston Company, 1012 Walnut Street, Philadelphia, Pa., 1950.

A TEXTBOOK OF X-RAY DIAGNOSIS by British Authors in Four Volumes. Second Edition. Edited by: S. Cochrane Shanks, M.D., director, X-Ray Diagnostic Department, University College Hospital, London; and Peter Kerley, M.D., director, X-Ray Department, Westminster Hospital, London. 592 pages, with 553 illustrations. Price $15.00. W. B. Saunders Company, West Washington Square, Philadelphia, Pa., 1950.

BOOKS REVIEWED

SEX WITHOUT FEAR. By S. A. Lewin, M.D., and John Gilmore, Ph.D. 121 pages, with 46 illustrations. Price $3.00. Lear Publishers, Inc., 105 East 15th Street, New York 3, New York, 1950.

This is a well-prepared and vividly illustrated sex manual, intended for lay reading.

It points out the importance of sex knowledge for a successful marriage, and also the general lack of sex education. A large part of the book is devoted to the anatomy and physiology of the reproductive system. The illustrations are very well done, but photomicrographs are of questionable value in a text prepared for lay reading.

Contraceptive methods are discussed at some length and probably overemphasized, since it has been repeatedly observed that relatively infertile women practice contraception during the early years of their reproductive period and are unable to conceive later when they decide to have a baby. Also, the present high rate of pelvic endometriosis appears to be associated with postponement of pregnancy.

The so-called male climacteric is discussed. The authors state that loss of sex vigor in older men may be restored by hormone therapy. This observation has not been general. The book is worth reading for married couples and also those contemplating marriage.

D. A. B.

ESSENTIALS OF OBSTETRICAL AND GYNECOLOGICAL PATHOLOGY. By Robert L. Faulkner, M.D., Assistant Professor of Gynecology, the Western Reserve Medical School; and Marion Douglass, M.D., formerly Assistant Professor of Gynecology, the Western Reserve Medical School. Second edition. 357 pages, with 300 illustrations, including 3 color plates. Price $8.75. The C. V. Mosby Company, St. Louis, 1949.

It is clear that this book has merit, else a second edition would not have been published. This is an unusually well printed text, with clear illustrations and succinct descriptions. In a few instances it is perhaps too brief, but on the whole it should make an excellent reference work for any busy practitioner, and in addition its perusal will reward him with many practical clinical points in differential diagnosis. The diction is a clear, almost non-technical style of English, most unusual in medical texts.

The surgeon, especially the occasional surgeon, who does any laparotomies in women, and who does not have access to a good pathological laboratory, would do well to avail himself of the help offered in this book. His patients cannot fail to benefit.

While the section on pregnancy is brief, it is well presented and contains much interesting material on the placenta, including a caution against making a diagnosis of syphilis from the microscopic appearance of the placenta without other evidence. There is a wholesome discussion of chorionepithelioma,—"wholesome" because it abandons the older, partially dogmatic approach and gives instead a resumé of the known facts and the pathologist's difficulties in regard to this particular tumor. Obstetricians will inspect placentae with more interest after perusing this section.

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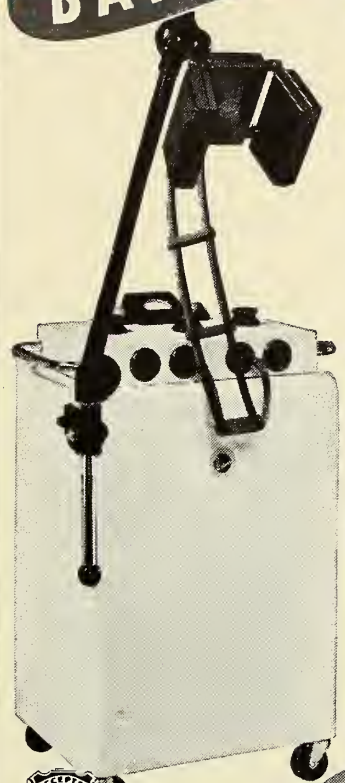

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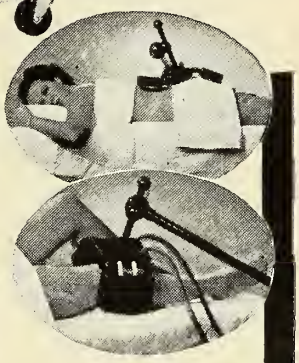

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TEXTBOOK OF ENDOCRINOLOGY. Edited by Robert H. Williams, M.D., executive officer and professor of medicine, University of Washington Medical School, Seattle. 793 pages, with 168 figures. Price $10.00. W. B. Saunders Company, Philadelphia, 1950.

Doctor Williams and an able group of collaborators have presented here an authoritative and up-to-date statement of the physiology and the disturbances of the endocrine glands. Fundamental research is thoroughly analyzed. Orientation is established by an excellent introductory chapter on general principles of endocrinology. The various sections are uniformly well done. It is difficult to single out for commendation particular sections and their authors. In the section on the parathyroids, Dr. E. C. Reifenstein presents an unusually good discussion of diseases of bone. In the chapter on obesity, Dr. Newburgh's emphasis on the factor of overeating will furnish reassurance to doctors who hesitate to apply this principle generally. The attempt to make the book definitive leads to some over-long presentations of rare conditions, such as that of adrenal hyperfunction. The detailed review of physiology and investigative work makes the book difficult for the average reader who is looking for help in the handling of his endocrine patients. It is unfortunate that so many of the procedures outlined for precise practice in the field of endocrinology are available in so few places. Nevertheless this book can be recommended to any physician interested in the treatment of endocrine disorders. The details of management are thoroughly covered throughout the text. The discussions of diagnosis and of management in each of the fields will prove valuable whether or not the doctor is interested in the fundamental physiology and the experimental background on which they are based.

S. L. J.

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Disease	July 1950	June 1950	May 1950	July 1949	July 1948
Brucellosis	4	6	2	5	5
Chickenpox	33	131	278	30	48
Diphtheria	6	4	13	32	18
Dysentery, Unspecified	2	0	0	4	0
Encephalitis	1	4	1	5	3
Food Poisoning	2	9	3	7	2
Measles	282	1167	2244	167	230
Meningitis, Unclassified	1	1	2	2	7
Influenzal	1	2	1	0	0
Meningococcal	1	3	4	2	3
Pneumococcal	1	0	2	2	0
Mumps	16	74	125	65	69
Paratyphoid fever	1	0	0	0	1
Pneumonia	25	25	20	10	21
Poliomyelitis, Paralytic	7	0	0	138	26
Nonparalytic	3	1	0	61	16
Unspecified	13	4	3	49	0
Rabies in animals	60	62	52	69	82
Rheumatic fever	1	0	0	1	2
Rocky Mt. Spotted Fever	3	3	0	4	2
Rubella	1	39	83	10	10
Scarlet fever	21	47	170	25	41
Septic Sore Throat	1	0	0	8	5
Tinea capitis	2	3	21	1	6
Trichinosis	2	0	0	1	1
Tuberculosis, Pulmonary	189	174	206	204	315
Other forms	13	15	30	18	13
Typhoid fever	1	4	1	8	10
Vincent's angina	3	1	0	1	1
Whooping cough	131	137	176	116	45

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INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

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VOLUME 43 OCTOBER, 1950 NUMBER 10

PRESIDENT'S ADDRESS*

C. S. Black, M.D.

WARREN

THIS is the beginning of the last week of my presidency of the Indiana State Medical Association, and I want to assure you it has been a very pleasant year for me. It climaxes my many years in the practice of medicine in Indiana, and I deem it a great honor to have been your president.

Every division of the state association has functioned smoothly, thanks to very efficient help in the headquarters office and to all active committee members.

One of the year's new developments is the Subcommittee on Grievances under the Public Relations Committee. I feel that this Grievance Committee has helped considerably in furthering better public relations. Another new development is the Coordinating Committee. Dr. Cleon Nafe and Mrs. Truman Caylor, who represents the Auxiliary, work with the A.M.A. in planning the fight against socialized medicine.

We are glad the 81st Congress has seen fit to reject the administration's national health plan. We will soon see how effective the medical profession's educational programs have been in preventing the election of proponents of socialized medicine. We have not conducted a partisan campaign; our one aim has been to clarify the issue of socialized medicine so that people will know exactly what they're voting for or against. We, like the Marines, must keep "constant vigilance and eternal suspicion," for we cannot let our profession become just another political bureau under the direction of a federal administrator who may not even know the difference between Lydia Pinkham and Carrie Nation.

Protect the privilege of writing your own prescriptions by paying your state and A.M.A. dues. It has been said that the way to lose your freedom is to get into the penitentiary. The medical profession will most certainly lose its freedom if we get into socialized medicine, and I think we would all rather be like the Negro who, after the Civil War, was asked if he wouldn't rather be cared for by his master and thus be relieved of responsibility. He replied that no, he sort of enjoyed his careless freedom.

Once again war clouds are hanging over us, and the government is asking for medical personnel. We are doing our best to supply this need by volunteer enlistment, although a law has been passed to draft doctors. Medicine is a profession of service, and we stand ready to serve those who need us most. Our greatest obligation is therefore to the men in the armed forces who are willing to give their lives for the ideals of democracy and the preservation of freedom.

On the home front, complaints on medical costs have been brought to our attention, especially by the federal government. To get the true picture before the public, we should separate the medical service bill—or what the doctor receives—from laboratory, hospital and x-ray fees, to show where the heavy cost falls. People demand laboratory,

* Presented before the General Meeting of the Indiana State Medical Association, at French Lick, on September 26, 1950.

hospital and x-ray services, yet the whole cost is naturally hung on the doctor, when actually his fee is, in itself, only a reasonable part of the total amount. We regret that some doctors do overcharge their patients, and we are all branded for the misdeeds of a few. Let's not do anything to ring down an iron curtain on ourselves.

On the brighter side, we doctors in Indiana have long enjoyed a state medical journal that is outstanding among scientific publications in the United States. We thank Dr. Frank Ramsey and his splendid editorial and production associates for keeping us supplied with the latest and best in good medical reading.

It has been a great pleasure to me to have every man in this organization function in whatever capacity he was asked to fill, and I could not have had a more capable assistant and faithful worker than your president-elect, Doctor Ellison. I predict for him an excellent year ahead if you will give him the same loyal support you have so graciously given me.

MYOCARDIAL INFARCTION DUE TO SYPHILITIC OSTIAL STENOSIS†

Report of a Case

Charles Fisch, M.D. and David Rosenbaum, M.D.*

INDIANAPOLIS

THE occurrence of myocardial infarction secondary to stenosis of the coronary ostia as a result of syphilitic aortitis is rare. In our search of the literature we were able to find twelve cases of myocardial infarction which were thought to be due to such stenosis.[1-6] A complete review of the literature regarding this subject can be found in a paper by Burch and Winsor.[6] The rarity of myocardial infarction resulting from coronary ostial occlusion complicating syphilitic aortitis is of interest if one considers the frequence and severity of such ostial stenosis. The incidence of the latter was found to vary from 19.9 percent in the series reported by Clawson and Bell[7] to as high as 35 percent in the series reported by Saphir and Scott.[8] In view of the infrequency of such an etiology of myocardial infarction it was thought worth-while to report the following case.

CASE REPORT

History and Physical Examination: The patient, a 56-year-old colored male, was first admitted to the Veterans Administration Hospital, Indianapolis, on December 30, 1947. His chief complaints on admission were precordial pain and nocturnal dyspnea, both of two years' duration. The pain was initiated by exertion and disappeared with rest. The nocturnal dyspnea had become more frequent during the six months preceding admission to the hospital. Physical examination disclosed a well-developed and well-nourished negro male weighing 175 pounds (79 kilograms) and measuring 67 inches (167 cm.) in height. The temperature was 98.6 (37 degrees C), the pulse 72 per minute and the respiratory rate 18. Capillary pulsation and Duroziez's sign were present. The carotid pulsations were exaggerated. The blood pressure was 164 millimeters of mercury systolic, and 60 millimeters of mercury diastolic. The apical impulse was heaving in nature. The left border of the heart was found to be to the left of the midclavicular line. A diastolic thrill was palpable at the aortic area. The first heart sound at the mitral area was accentuated. The second aortic sound was tambour in quality with systolic and diastolic murmurs heard in that area. Examination of the lungs revealed the presence of moist rales in both bases. The remainder of the physical examination was not revealing.

Laboratory: Complete blood count, hemoglobin, and urinalysis were within normal limits. The Kahn and Kolmer reactions were strongly positive on two different occasions. Fluoroscopic and

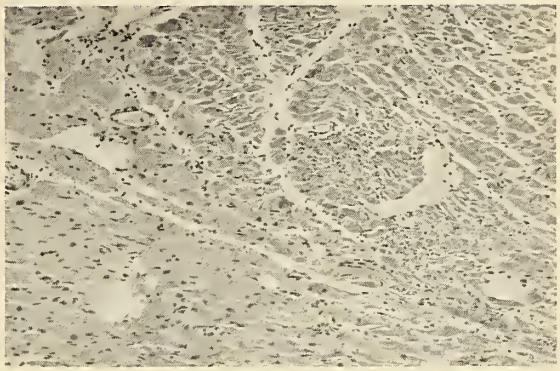
† Published with the permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions expressed or conclusions drawn by the authors.

* From the Departments of Medicine and Pathology, Veterans Administration Hospital, Indianapolis, Indiana.

Figure 1

Photograph of heart showing extreme narrowing of left (A) and right (B) coronary orifices. The right coronary ostium is partially hidden in an artefactual fissure in the aorta.

Figure 2



Low power photomicrograph of edge of myocardial infarct, showing a typical staining of myocardial fibers, pyknosis of some nuclei, and zone of inflammatory infiltration at the periphery of the infarct.

roentgenographic examination of the heart disclosed enlargement of the left ventricle and evidence of calcification of the first portion of the aorta. The latter was best seen in the left anterior oblique position. The lung fields showed congestive changes in the right base. Electrocardiograms revealed a deep Q-3 and inverted T-waves in leads 2 and 3. A diphasic T-wave was seen in lead CF-4 and inverted T-waves with depression of the S-T segments in leads CF-5 and CF-6. The venous pressure was 182 centimeters of water. Arm to tongue circulation time, using calcium gluconate, was 22 seconds, and arm to lung circulation time, using ether, was 12 seconds.

Clinical Course: The patient was treated with restriction of activities, digitalis, diuretics and a diet poor in salt. The subjective symptoms and evidence of congestive failure disappeared and the patient was discharged on January 30, 1948. He was readmitted at 10:00 A.M. on March 16, 1948. At that time he was complaining of excruciating retrosternal and epigastric pain. No history pertaining to the terminal episode was obtainable, since the patient was confused and disoriented. He was in a state of deep shock with neither the blood pressure nor the pulse obtainable. He remained in this condition until his death which occurred two hours after admission.

Autopsy: Autopsy was performed by one of us (D.R.) two and one-half hours after death. The essential findings were in the heart, blood vessels and lungs. The heart weighed 470 grams and showed moderate hypertrophy and considerable dilatation of the left ventricle. An indefinite area of greyish-brown discoloration, about 4 centimeters in its greatest dimension, was found in the anterior wall of the left ventricle and the contiguous anterior upper portion of the interventricular septum. This area was of slightly softer consistency than the rest of the myocardium. It was poorly demarcated from the surrounding myocardium by a zone of slightly reddish discoloration. The cusps of the aortic valve were markedly thickened, opaque and greyish-white. There was considerable rolling of the free edges and shortening of the cusps. The commissures were widened and that between the left coronary cusp and noncoronary cusp measured 1 centimeter in width. The ostia of both coronary arteries were almost completely closed (Fig. 1) and a probe could not be introduced into either one without force. Beyond the ostia, the coronary arteries exhibited occasional atheromatous plaques without occlusion or significant narrowing. The first portion of the aorta was greatly dilated but showed no localized aneurysm. Calcification in this region was very extensive. There were considerable numbers of greyish, slightly elevated, translucent, firm areas presenting on the intimal surface of the aorta, especially in the thoracic portion. These varied from 0.2 centimeters to 1 centimeter in diameter. Marked longitudinal wrinkling of the intima was seen throughout the thoracic aorta. There was marked loss of elasticity in this portion of the vessel.

Histologically (Fig. 2), the involved area of myocardium exhibited poor staining of the muscle fibers with partial loss of nuclear staining. At the edges of the lesion, there was some inflammatory infiltration among the muscle fibers, the inflammatory cells being predominately polymorphonuclear leukocytes. Some erythrocytes were also seen in this zone. Sections through the aorta exhibited considerable loss of elastic tissue and perivascular lymphocytic and plasma cell infiltration about the vasa vasavorum. This perivascular infiltrate was particularly marked in the adventitia although some was seen in the media. Gross and microscopic examination of the lungs revealed severe pulmonary edema. The final diagnoses were syphilitic aortitis with calcification, syphilitic aortic valvulitis with aortic insufficiency, hypertrophy and dilatation of the left ventricle, recent myo-

cardial infarction of the left ventricle and interventricular septum on the basis of syphilitic stenosis of the coronary ostia, and pulmonary edema.

DISCUSSION

Coronary ostial stenosis is a rather common complication of syphilitic aortitis, yet a search of the literature revealed only twelve previously reported instances in which this deformity ultimately lead to myocardial infarction. It is a well-known fact that many patients with luetic aortic insufficiency die rather suddenly. It is quite possible that many of these suffer from sudden and marked myocardial ischemia resulting in death before any demonstrable changes can take place in the heart muscle. In studying a case such as the present one, two questions immediately arise: (1) Was the myocardial infarction due to an associated arteriosclerosis and thrombosis of the coronary arteries; (2) Did the myocardial infarction in this case represent an instance of infarction without demonstrable coronary closure and entirely independent of coronary ostial stenosis? To answer the former of the two a careful examination of the coronary arteries was done and no evidence of occlusion was found. The latter question is very difficult, if not impossible, to answer beyond any shadow of doubt. However, in view of marked coronary ostial narrowing and absence of any coronary thrombosis, it was thought reasonable to assume that the myocardial infarction was due to syphilitic coronary ostial stenosis.

SUMMARY

1. An instance of myocardial infarction secondary to syphilitic aortitis with coronary ostial stenosis is reported.
2. The literature bearing on this condition is briefly reviewed.

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ARMY REDUCES RECALLS OF WW II PHYSICIANS, DENTISTS

Army area commanders have received new instructions relative to the recall of reserve medical, dental and veterinary officers which should reduce the number with World War II service to be called from 50 to 75 percent.

The new move, taken in view of legislation providing for selective induction of physicians, dentists and members of other allied professions, will have the effect of limiting the recall of officers with World War II service to a maximum of 364 physicians, 126 dentists and 29 veterinarians. The actual number recalled will be considerably less than this figure, it was estimated. This is a later announcement and the figures supersede those mentioned in the news note on page 1030.

TRAUMATIC INJURIES TO THE LIVER AND SPLEEN

The Leukocyte Counts As An Aid In Diagnosis

J. K. Berman, M.D., and W. Vernon Lee, M.D.

INDIANAPOLIS

MOST TEXTBOOKS refer to injuries of the head, thorax, abdomen or extremities and proceed to describe the symptoms and signs and laboratory findings of such trauma in the various anatomical parts mentioned. However, in most instances injuries are not confined to one portion of the body. They are multiple wounds as a rule, which often involve the head, thorax, abdomen and extremities as well. This is particularly true of automobile accidents where contusions predominate, rather than lacerations, penetrating or perforating wounds. Our studies do not include spontaneous rupture of diseased livers or spleens and all of our patients had normal livers and spleens proved by microscopic studies.

Perforating wounds of the abdomen may present a diagnostic problem as to their depth, but the site of the perforation is a guide to the organ or organs injured, and if the trajectory of the bullet or the direction of the knife or other object can be ascertained a fair degree of accuracy may be expected in diagnosing the organs which have been damaged. However, in contused wounds, particularly where there are multiple injuries, it is often difficult to be sure that an intraabdominal injury is present, and moreover it is hard to decide whether or not exploration is indicated. The word *exploration* as ordinarily used for the abdomen carries with it the thought that the procedure is more or less innocuous. However, in patients who have been badly traumatized and are in a state of shock, and who have multiple injuries to other parts of the body, an unnecessary exploration may be the deciding factor in survival or death. In uncomplicated injuries in which splenic rupture is suspected, patients are often released only to return with delayed rupture.

METHODS OF DIAGNOSIS

The diagnosis of an injured spleen or liver rests upon a careful history and the evaluation of the symptoms and signs which are present. Among the latter may be listed: pain, tenderness, local muscle rigidity, perhaps an increase in the size of the spleen if it can be palpated; pain in the left shoulder which is thought to be due to an irritation of the diaphragm (Kehr's sign),[1] and an area of increased dullness in the splenic area which was described by Ballance in 1898.[2] In doubtful cases other aids may be helpful. A "scout" film of the abdomen will show an increased density in the left upper quadrant elevation of the left diaphragm and displacement of the stomach toward the right side. There may be evidence of free fluid between the loops of intestines. A study of the stomach shadow will frequently disclose a large amount of gas, an irregular outline of the greater curvature in splenic injuries and prominent rugae. (See figure 1.) The same is true of the lesser curvature of the stomach when the liver has been injured. (Figure 2.) One way to make the diagnosis is the "wait and see" policy. One waits to determine whether or not replacement of fluid brings the patient out of shock and if so for how long. If restoration of blood volume is followed by rapid and repeated returns to shock it is logically construed to mean that blood is being lost as rapidly as it is being administered and, therefore, one of the parenchymatous organs or a large vessel has been torn and operation is necessary. It is apparent that this method of making the diagnosis wastes very valuable time during which the patient may slip into a state of irreversible shock.

Another method of diagnosis is an attempt to determine what is being lost within the abdomen (intestinal content or blood) by abdominal paracentesis carefully done or by peritoneoscopy. We have not used the latter; however, on several occasions we have attempted to use the former. If the blood is clotted, (and it does so rapidly within the abdomen, especially in splenic injury), it is difficult to obtain samples of peritoneal exudate or transudate unless a very large needle is used and introduced in various directions. Since the extent of the injury is not determined we have found this procedure to be not only unsafe but of little help.

Lastly we may turn to blood studies. Before the shift of intercellular fluid has occurred uncompensated blood loss is difficult to determine by a study of the blood picture alone. After the shift, which may take anywhere from two hours to three days, one may obtain a fair idea of the amount of blood lost, provided there was an adequate amount of fluid in the intercellular tissue spaces. For example, in an indivdual who is more or less dehydrated when the accident occurs the fluid replacement will be less, and therefore the hemato-

From the Department of Surgery of the Indianapolis General Hospital and the Charles J. Wolf Foundation for Medical Research, Indianapolis.

Figure 1

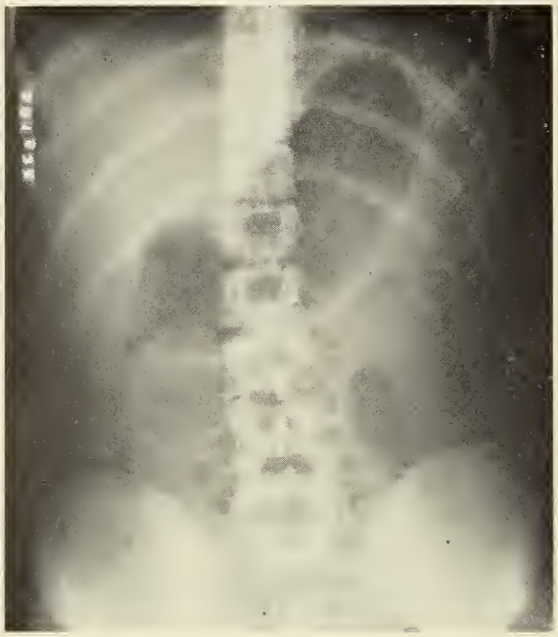


Figure 2

crit and plasma protein and blood counts will be misleading; whereas if the interstitial "cushion" is filled with an adequate amount of fluid, replacement is adequate and there will be a fall in the red blood count, hemoglobin and the hematocrit. However, this may be greatly delayed and may not occur until the second or third day.[3, 4] Therefore, unreplaced blood loss is not an accurate method of determining the extent of bleeding, and moreover it is dangerous to wait until the picture is more accurate, because of progressive shock due to the great disproportion between the circulating blood volume and the vascular tree. If blood loss is restored the blood count is unreliable because of the fluids and blood which have been administered.

LEUKOCYTE COUNT IN CONTUSIONS TO THE LIVER AND SPLEEN

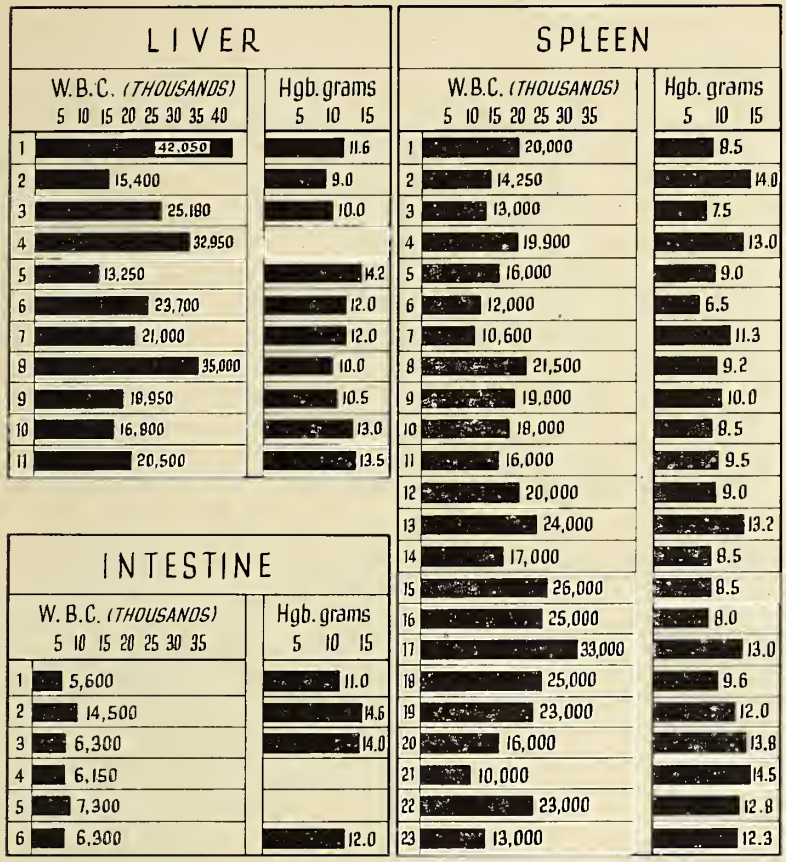
Krieg[5] studied 60 cases of hepatic trauma; 68 percent were gunshot wounds of the liver, 17 percent traumatic injuries, and 15 percent were stab wounds. He showed that the hemoglobin varied anywhere from 40 to 90 percent and that the white blood count varied from normal to 33,000. However, in 62 percent of the cases which he studied the leukocytes numbered above 10,000. Many of the textbooks on surgery state that there is a rapid increase in the number of leukocytes which is not accompanied by a fall in the hemoglobin value and in the red blood cell count. Usually this is attributed to the presence of blood in the peritoneal cavity. Although this observation has been borne out by the present study we have found that the leukocytes do not maintain their increase even though there is no decrease in the erythrocyte count, indicating that hemorrhage alone is probably not the cause of the leukocytosis. Moreover, if one depends upon the leukocyte counts after the first six hours of injury he will be misled.

During the last eight years we have observed the leukocyte counts in hepatic and splenic damage and we have made comparative studies in 196 cases of traumatic injuries. These include injuries to the liver, the spleen, the intestines and other organs, such as the stomach, urinary bladder, kidney, chest, retroperitoneal space and the abdominal wall. We have separated our cases into the following groups: (1) traumatic injury of the liver, spleen and intestines and other organs; (2) gunshot wounds of the liver, spleen and intestines and other organs; and (3) stab wounds of the liver, spleen, intestines and other organs as indicated in our graphs. (Figures 3 and 4.)

We have found that a double check leukocyte count offers a great amount of information concerning the presence of splenic or liver injury. These counts are made routinely on all patients immediately upon admission to the hospital. The accompanying charts reveal that when the spleen is injured there is a quick rise in the number of leukocytes and when the liver is injured there is an even greater rise in the leukocyte count. This test is most reliable only when it is done on admission. If it is checked within an hour or two it will be found that in spite of the hemo-

Figure 3

LEUKOCYTE COUNT AND HEMOGLOBIN DETERMINATION IN TRAUMATIC RUPTURE OF LIVER, SPLEEN *and* INTESTINE



dilution due to fluid shifts, the leukocyte counts are still high. However, twenty-four hours later it will be found that the leukocytes have fallen even though the erythrocytes may remain relatively high. Therefore the test is only reliable during the first few hours after the accident. The rapid increase in the number of leukocytes is fairly constant, and when compared with the number of white blood cells in other types of injuries it stands out as a very valuable sign to be used with other methods of diagnosis. There will be great variations in individual cases of splenic and hepatic injuries and there will be differences in counts depending upon the type of trauma inflicted. (See figure 3.) Traumatic rupture of the spleen was studied in twenty-three cases. The leukocyte counts in this group varied from 10,000 to 33,000, the hemoglobin varied from 6.5 grams to 14.5 grams. Counts in traumatic rupture of the liver varied from 13,250 to 42,050 and the hemoglobin varied from 9.0 to 14.2 grams. In traumatic rupture of the intestine the leukocyte count varied from 5,600 to 14,500 and the hemoglobin varied from 11.0 to 14.6 grams.

Figure 4 shows the *average* counts in traumatic rupture of the liver, spleen and intestine, as compared with gunshot and stab wounds of these organs and of other sites. Several very important features should be noted. In traumatic injury of the liver the count is highest, gunshot wounds next and stab wounds least. In other words, there is a progressive diminution in average counts as compared with the progressive increase in the hemoglobin. Stated in another way, the highest counts are noted in the cases with the lowest hemoglobin. This could mean that in spite of hemodilution or of actual blood loss the leukocytes nevertheless rise to exceedingly high levels. Traumatic ruptures of the spleen follow the same pattern; *i.e.*, the leukocytes are greatest when the hemoglobin is least. Since there was only one stab wound of the spleen in this series an asterisk is used to call attention to the fact that this may have been an error.

A study of the average counts in intestinal injury shows a reverse effect; namely, the lowest counts are seen in traumatic injuries to the intestine and the higher counts in gunshot and stab wounds. Conversely, along with the lowest leukocyte count the hemoglobin is highest in traumatic rupture (probably because of smaller blood loss), and lowest in stab wounds.

The counts in chest, stomach, bladder, kidney, retroperitoneal injuries, and trauma to the abdominal wall are equivocal, and no great significance can be attached to these findings except in comparison with splenic, liver and intestinal injuries. The number of white cells are about the same whether the wounds are due to trauma, gunshot or stabbing. However, here again the highest count is in the traumatic rupture cases although the hemoglobin is not the lowest.

These studies show the prodigious increase in the number of leukocytes from trauma to the liver and to the spleen, and the comparatively low or normal leukocyte count when the trauma produces rupture of the intestine. However, the reverse is true in gunshot wounds of the liver and spleen and the intestine. In gunshot and stab wounds of the liver the count is less high,

and the same is true of the spleen; whereas in gunshot and stab wounds of the intestine the counts rise to higher levels. Damage to other organs shows no great differences in leukocyte counts between traumas without external wounds, gunshot wounds and stab wounds. However, the total average count does not approach the heights reached by injuries to the liver and spleen. (See figures 3 and 4.)

Figure 4

AVERAGE LEUKOCYTE COUNT AND HEMOGLOBIN DETERMINATION IN TRAUMATIC RUPTURE COMPARED WITH GUNSHOT *and* STAB WOUNDS OF THE LIVER, SPLEEN, INTESTINES *and* OTHER SITES.

SITE OF INJURY	TYPE OF INJURY		W.B.C. (THOUSANDS) 5 10 15 20 25 30 35	Hgb. in grams 5 10 15
LIVER	TRAUMA (Rupture)	11 CASES	24,800	11.5
	GUNSHOT WOUND	21 CASES	16,400	12.3
	STAB WOUND	7 CASES	12,200	13.2
SPLEEN	TRAUMA (Rupture)	23 CASES	18,270	10.6
	GUNSHOT WOUND	3 CASES	13,400	14.
	STAB WOUND	1 CASE	33,800 *	13.1
INTESTINE	TRAUMA (Rupture)	6 CASES	7,692	12.9
	GUNSHOT WOUND	30 CASES	11,670	11.3
	STAB WOUND	9 CASES	11,700	10.3
CHEST, STOMACH, BLADDER, KIDNEY, RETROPERITONEAL AREA AND ABDOMINAL WALL	TRAUMA (Rupture)	5 CASES	11,930	12.1
	GUNSHOT WOUND	30 CASES	11,670	11.3
	STAB WOUND	50 CASES	9,650	12.6

PROBABLE CAUSES FOR LEUKOCYTOSIS IN HEPATIC AND SPLENIC INJURY

The spleen is an organ full of reticulo-endothelial cells which contracts and liberates a large amount of antigen when traumatized, calling forth a prompt reaction while the patient is still able to react. In the liver, where more antigen is usually thought to be present, an even greater and more precipitous rise in the leukocyte counts is observed. The degree of the tear is not always predictable by the white blood count, although a small rent in the liver may give a higher leukocyte count than a large rent in the spleen, and a very large rent in the liver will usually give a higher count than a small one. However, in gunshot and stab wounds of these organs the number of leukocytes is less. This may be due to the fact that fewer cells have been traumatized. This has been true with the exception of the one case of stab wound of the spleen which we have cited previously and in which there was a 33,800 leukocyte count. This may have been an error. Gunshot and stab wounds of the intestines call forth more leukocytes than lacerated wounds due to blunt trauma. This phenomenon may be due to the fact that there is less spillage usually in the latter. In combined injuries which include the liver or spleen, leukocyte counts are almost invariably higher. Therefore a precipitous rise in the leukocytes indicates possible damage to the liver and spleen, and since it occurs usually with a concomitant fall in hemoglobin the hemodilution may mask the true rise in the number of white blood cells.

CONCLUSIONS

1. A careful study of the leukocyte counts in the early phases of abdominal trauma will serve as an additional aid in the diagnosis of injuries to the liver and spleen;

2. These counts are reliable only during the first few hours of the injury and before any replacements of fluid have been instigated;

3. Observations tend to show that the leukocyte counts are higher in ruptured wounds than in perforating or penetrating wounds. At the same time, these injuries are accompanied by the greatest fall in hemoglobin. Since it is in the contused wound that the diagnosis is more obscure, the test becomes increasingly valuable.

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(We are indebted to Drs. Howard Rothering and John Kneidel for their help in interpreting x-ray films.)

THE CAUSES OF DEATH IN ANEURYSM OF THE HEART: INCIDENCE OF ACUTE CORONARY ARTERY THROMBOSIS IN ESTABLISHED CASES

Report of A Case*†

WENDELL A. SHULLENBERGER, M.D.

INDIANAPOLIS

THE OCCURRENCE of aneurysm of the heart is not to be regarded as a matter merely of medical curiosity. As a diagnostic problem and a pathological entity it has been the subject of serious study, which the accompanying references will disclose, but no collective study as to prognosis has appeared. Two recently published series of post-mortem studies on very large numbers of cases, one by Wang, Bland and White[1] and the other by Betsch,[2] reveal that aneurysm occurs in 8 to 10 percent of all cases of myocardial infarction and would seem to justify an inquiry into the cardiac history of patients in whose hearts an aneurysm has become established.

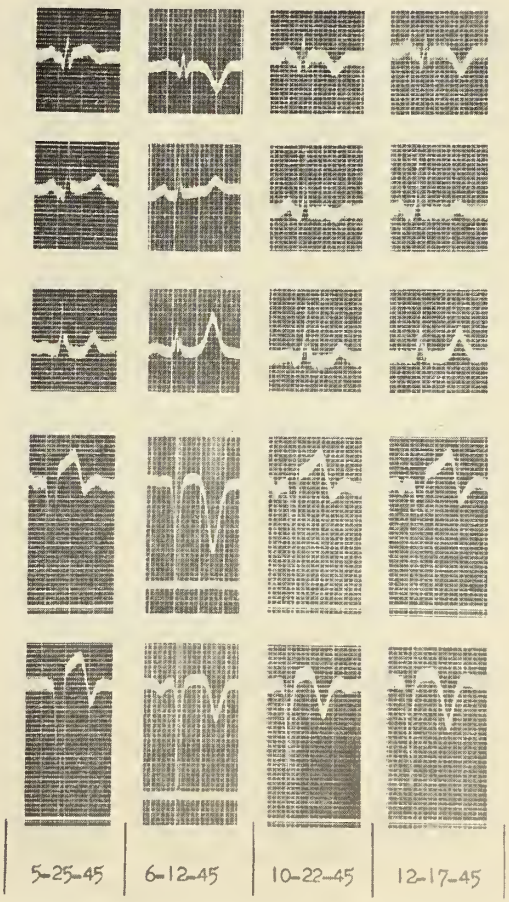
It is frequently stated in the literature of cardiac aneurysm that the conditon is not incompatible with a considerable degree of physical activity and it is a fact that, despite their spectacular pathologic features, these aneurysms, when fully healed and fibrosed, undergo rupture so infrequently as to make reports of that event worthy of addition to medical knowledge. Cases have been reported to have lived as long as seven years[3] following myocardial infarction before aneurysm was diagnosed, though the sac must have been present during the greater part of that period of time.

The usual causes of death following establishment of this condition in the heart are congestive failure, "sudden death," and rupture of the aneurysm, as will be shown. The second group is worthy of more attention and, though histories of several patients in this group have been published in detail, the case reported here is believed to be unusual in the nature of the terminal event and in that it was possible to follow by electrocardiography the sequence of changes responsible for death. It also illustrates that economic disability need not accompany an apparently grave cardiac lesion.

CASE HISTORY

A man, 50 years old, known to have had high blood pressure for several years, had three attacks of rather severe epigastric pain over a period of ten days. Although his pains were accompanied by sweating and weakness he refused to go to bed until after the third attack. A diagnosis of coronary thrombosis and anterior wall infarction of the myocardium was made by electrocardiogram on the eleventh day after his first attack of pain (figure 1, 5-25-45). He was placed in the hospital and at the end of three uneventful weeks a routine bedside chest film showed tremendous cardiac enlargement and a silhouette suggesting

Figure 1



Electrocardiograms on dates as indicated. The leads from above downward are 1, 2, 3, CF2, CF5.

* From the Division of Internal Medicine, Methodist Hospital, Indianapolis, Indiana.

† Presented at the Annual Meeting of the Midwestern Section of the American Federation for Clinical Research, Chicago, October 28, 1948.

Figure 2

Roentgenogram of chest (patient supine) taken approximately 4½ weeks after first attack of pain.

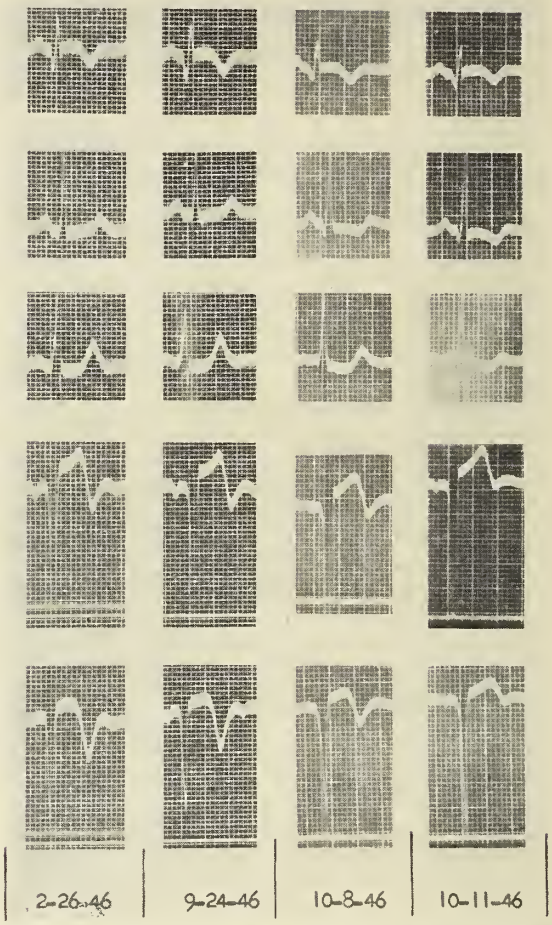
the presence of an aneurysm of the heart (figure 2).

After three more weeks in bed the patient became gradually ambulatory and returned to his regular business duties at the end of three and one-half months. The pulsatile sign of aneurysm of the heart in the left anterior chest wall appeared toward the end of this period and changes as of acute infarction occurred in the ST segment and T wave of Lead 2 and in ST in the precordial leads of his electrocardiogram (figure 1, 10-22-45). He experienced no pain or breathlessness.

During the following thirteen months the patient worked five to seven hours daily as a sales-manager and made several short overnight business trips. He occasionally mentioned slight breathlessness after a full meal but was not apparently short of breath on moderate effort. The ST segment and T wave in Lead 2 had returned to normal within a few weeks, but the elevation of ST in the precordial leads persisted (figure 1, 12-17-45; figure 3, 2-26-46).

Sixteen months after his original attacks, this patient was again hospitalized because of persistent mild attacks of high epigastric pain. An electrocardiogram a few days before hospital admission showed practically no change from previous tracings (figure 3, 9-24-46), but those taken after he was admitted showed progressive depression of the ST segment and deterioration of the T wave in Leads 2 and 3 (figure 3, 10-8-46 and 10-11-46). Figure 4 shows graphically the progression of changes in leads 2 and 3 of the electrocardiograms. These changes were interpreted as indicating increasing ischemia of the posterior wall of the ventricle. Death occurred suddenly and without warning early in the morning while the patient was yet in bed.

Figure 3



Electrocardiograms on dates as indicated. The leads from above downward are 1, 2, 3, CF2, CF5.

The autopsy by Dr. H. M. Banks was reported as follows:

Heart: The heart is massively increased in size, and distorted in its shape. The heart weighs 1150 gms. There is a large bulging area measuring 8½ cm. in diameter on the anterior surface of the left ventricle. The auricles are dilated and contain post-mortem clots. There is no endocarditis, verrucae, ulcers, or vegetations in this region. The foramen ovale is closed. The ventricles are massively hypertrophied. They are both dilated. The papillary muscles are firm, the chorda tendinae are inserted into the valve leaflets. The septum is intact, but fibrosed in the area of the previously described aneurysm. The myocardium is a dark beefy red in color with the exception of the area immediately adjacent to the myocardium which is fibrosed and dull gray in color. The myocardium of the right ventricle on the posterior surface is somewhat deeper reddish brown, but no definite infarction is

Figure 4

Large scale facsimilies of electrocardiograms (Leads 1, 2, 3) showing changes in contour of ST segments and T waves near-terminally.

seen. The myocardium measures 2½ cm. in greatest thickness in the left ventricle and 1 cm. in greatest thickness of the right ventricle.

Valves: The valves are free of vegetations, rupture, stenosis. The commissures of the aortic valve are plastered together by atheromatotic plaques. There are no fenestrations. The remaining valve structures show a clean insertion of their commissures. The valve rings measure in circumference: aortic 7, mitral 9½, tricuspid 14 and pulmonary 7½ cm. respectively. The coronary orifices are patent, although the right coronary orifice is considerably narrowed. The left coronary is explored and found to be considerably narrowed by atheromatotic plaques; however, it is patent. The anterior descending branch of the left coronary is closed, from a distance of approximately 4 mm. from its orifice throughout the entire length. It is filled by atheromatotic material and fibrosed thrombus. This artery extends directly to the edge of the aneurysm. The right coronary orifice is patent, although as previously mentioned is narrowed. Upon opening the right coronary system at a distance of 4 cm. from the coronary orifice, there is seen a large atheromatotic plaque in the circumflex branch, which has partially occluded the lumen of the artery. This artery is completely occluded by the formation of a fresh thrombus which is rather densely adherent to the roughened walls of the coronary vessel at this site. As previously mentioned, the right ventricular myocardium is considerably congested, darker red in color, but no definite infarction is seen in this area.

Aorta: The aorta is free of anomalies or aneurysms. It is very firm, the endothelial lining is roughened irregularly by numerous atheromatotic plaques throughout the entire length of the aorta. Some of these plaques show calcification. The ductus arteriosus is closed.

Figures 5 and 6 show the aneurysm with the parietal pericardium in situ and after it has been removed, respectively. Figure 7 shows the cavity of the aneurysm opened, the mural thrombotic material partially removed and indicates clearly the thin but tough structure of the aneurysmal wall.

DISCUSSION

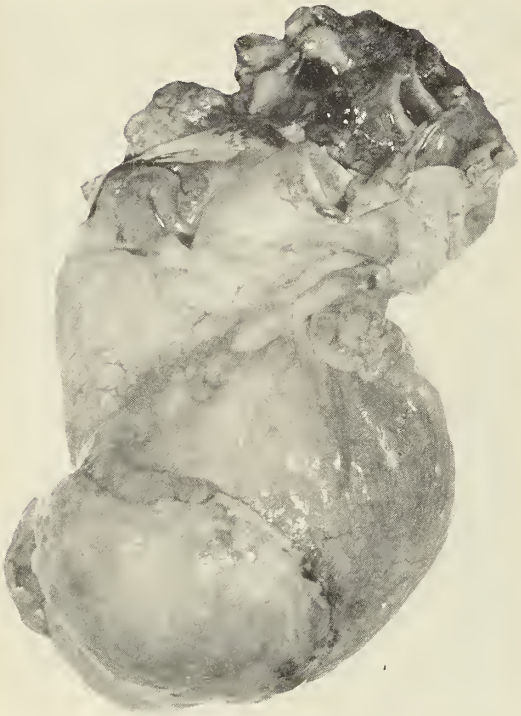
In reviewing recent medical literature on the subject of aneurysm of the heart, one rather frequently finds reference to the monograph of Sternberg,[4] and it seems likely that, prior to its publication in 1914, the relation of myocardial infarction to the development of these aneurysms was not appreciated. Sternberg thought that roentgenologic diagnosis of cardiac aneurysm would be possible and concluded that the disease, once established, would terminate after a lapse of a few weeks to several years in congestive heart failure or rupture of the aneurysm. Up to the present time emphasis has been mainly on the clinical recognition of this condition and on its most spectacular terminal event, namely, rupture of the aneurysm.

Much has been written concerning the diagnosis of aneurysm of the heart. Clinicians have come not to share the pessimism of Hall,[5] who wrote in 1903 that, "Aneurysms of the heart must necessarily be of interest rather to the pathologist than to the clinician, for they are outside the pale of practical diagnosis." Opinions have varied from that of Hall to that of Dressler and Pfeiffer,[6] who in 1940 stated that, "The diagnosis of cardiac aneurysm is based primarily on physical examination," and reported ten cases, nine of which were correctly diagnosed by means of physical examination alone.

Kraus[7] in 1919 was the first to report correlation between the findings by x-ray and those at autopsy. The presence in the left anterior chest wall of an aberrant heaving pulsation, which, to be diagnostic, must be determined to be separate and distinct from the true apical impulse was stressed by Harvier and Caruli,[8] by Christian and Frick[8] and by Libman.[9] Dressler and Pfeiffer[6] emphasized the importance of an area of pulsation which "is likely to be situated more craniad than one would expect for the apical thrust caused by an hypertrophied left ventricle." A first heart sound having dull or impaired quality is considered important by Libman[9] and Berk.[3] Parkinson, Bedford and Thomson[10] stated in 1938 that radiography was of primary importance in diagnosis.

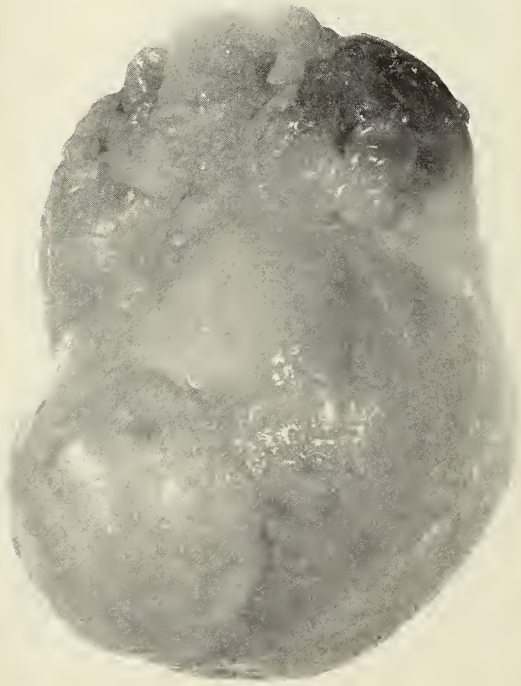
The place of electrocardiography in the diagnosis of aneurysm of the heart has been the subject of some detailed studies.[11, 12, 13] There is

Figure 5



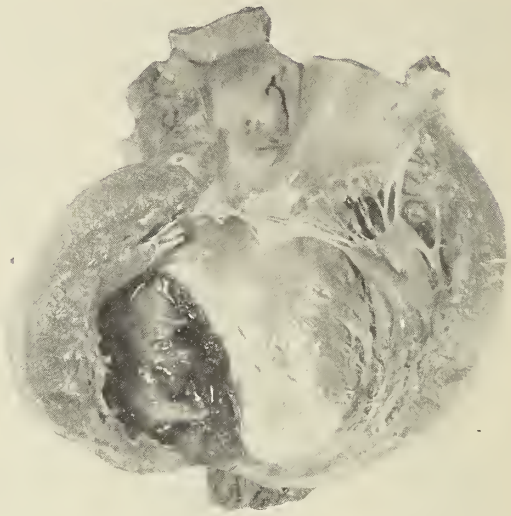
Heart showing parietal pericardium overlying aneurysm of left ventricle.

Figure 6



Heart showing aneurysm with parietal pericardium removed.

Figure 7



Heart with aneurysmal cavity laid open, mural thrombi mostly removed.

no diagnostic electrocardiographic pattern. However a useful rule of thumb is that persistence in the electrocardiogram of the features of acute myocardial infarction, after the clinical manifestations of that episode have subsided, should make one suspicious of the presence of an aneurysm.

Sternberg distinguished four stages in the history of cardiac aneurysms:

I. Attacks of cardiac pain, often of short duration;

II. Localized pericarditis at the site of infarction, occasionally producing pericardial friction rub;

III. Latency or apparent cure lasting several weeks to many years;

IV. Advanced myocardial disease associated with chronic hydrops or rupture.

If it is assumed that phases I and II cover the acute stage of the disease including the original coronary occlusion and myocardial infarction, the four points comprehend the history of a high percentage of these cases.

However, as pointed out in the opening statement and as reference to the tabulation in Figure 8 will show, a considerable number of patients have died neither in congestive failure nor from rupture of the aneurysm. A total of forty-six cases is tabulated from recently published articles and the case presented here is added to them. Of these forty-seven cases, only 26 had died up to the time of publication, in itself an interesting fact. In the twenty-six deaths, the causes of death are tabulated, including two cases of sudden

Figure 8

Tabulation of causes of death in 47 cases of cardiac aneurysm.

Total Cases	Ref.	Autopsy	Coronary Thrombosis	Cong. Failure	Rupture	Sudden Death	Other
1	(14)	1	1				
4	(9)	4		4			
3	(13)	2	1	1			
10 (2 deaths)	(6)	2				2 (Cor. Narrowing)	
2	(2)	2			2		
2	(15)	2					1 Lt. vent. failure 1 Cor. Insuff.
1	(16)	1	No fresh thrombosis				1 Lt. vent. failure
16 (7 deaths)	(10)	5		4		2 (no autopsy)	1 Cerebral Embolism
4 (2 deaths)	(3)	2		2			
1	(17)	1			1		
2 (1 dead)	(18)	0		1 (no autopsy)			
1	this report	1	1				
47 (26 deaths)		23	3 (11.5%)	12 (46%)	3 (11.5%)	4 (15.4%)	4 (Lt. vent. failure 7.7%) (15.4%)

death and one of congestive failure in which no autopsies were obtained.

It is clear that congestive heart failure is by far the most common cause of death (46 percent). Rupture of the aneurysm is not of frequent occurrence (11.5 percent proved at autopsy). Sudden death, the cause of which must remain speculative in two cases, occurred in four (15 percent) but was not due either to rupture of the aneurysm or to fresh coronary thrombosis in the two cases autopsied. Acute coronary thrombosis occurred in only three cases (11.5 percent). The incidence of pure failure of the left ventricle is surprisingly low (about 8 percent), considering the fact that most aneurysms reported have involved the left ventricle.

These figures are of some prognostic significance in view of the fact that, of the twenty-one living cases remaining, it is obvious from their case histories that a number of them were being carried on therapy for congestive heart failure at the time they were reported, whereas an episode clinically suggesting coronary thrombosis had apparently occurred in none subsequent to establishment of the diagnosis of aneurysm.

SUMMARY

Large autopsy series have disclosed that aneurysm of the myocardium occurs in about 10 percent of all cases of myocardial infarction. While the series studied in this report is small for fair statistical analysis, it would appear to show that the presence of so dramatic a pathologic condition in the musculature of the heart need not justify an immediately gloomy prognosis and that rupture of the aneurysm or subsequent coronary closure are relatively rare. Congestive failure is a common sequel to the establishment of aneurysm in the heart.

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CHRONIC RECURRENT PANCREATITIS

THEODORE S. MALINOWSKI, MAJOR, M.C.*

INDIANAPOLIS

CHRONIC RECURRENT pancreatitis frequently eludes the clinician and leads to erroneous diagonsis. Its clinical manifestations have been emphasized so frequently in the recent literature that the diagnosis is now readily established as evident by the number of cases reported. This does not imply that the incidence of the disease is necessarily increasing. More cases are recognized when this clinical entity is considered in patients with repeated painful seizures in the upper abdomen.

Comfort[1] and his associates have extensively studied chronic relapsing pancreatitis, especially those cases in which associated biliary tract disease did not exist. Chronic pancreatitis is a distinct clinical entity that typically manifests itself by frequent attacks of recurrent upper abdominal pain, by disturbance of function of acinar and islet cells and by definite sequelae. The acute painful exacerbations are characteristically recurrent, being separated by variable periods of relative quiescence. The interval between these acute exacerbations may vary from months to years. Each acute episode destroys more of the pancreatic tissue, and eventually permanent disturbance of the function of the acinar and islet cells results. Early in the disease the disturbances are temporary, being present only during the time of the acute attack.

It should be emphasized that chronic relapsing pancreatitis is a progressive disease; the acute episodes become more frequent, intense, and prolonged. As the disease progresses, the permanent disturbances of pancreatic function become apparent by the resulting diabetes, steatorrhea, and creatorrhea. The neighboring organs (common duct, gallbladder and duodenum) are at times affected and contribute to the entire clinical picture that usually presents itself. Chronic relapsing pancreatitis is frequently associated with biliary tract disease. Quite often the early episodes of recurrent pancreatitis are mistaken as manifestations of a known diseased gallbladder.

The following three cases illustrate the clincal manifestations and course of chronic recurrent pancreatitis.

Case I: A white man, aged 67, first entered the Medical Center on December 25, 1945, with a comminuted intertrochanteric fracture of the left hip. On December 28, 1945, surgery for the fracture was cancelled because of a shaking chill and temperature elevation. The temperature remained elevated (99-100°) for the next few days. On January 2, 1946, the patient had an acute painful seizure localized at first to the epigastrium, and later to the right abdomen. Along with the pain, he complained of nausea and vomiting. Physical examination revealed moderate degree of abdominal distention, tenderness and rigidity in the right mid-abdomen. This abdominal pain persisted for two days. A leukocytosis of 18,300 was found. Urinalysis was negative. Further inquiry at this time revealed that he had had several such acute painful seizures in the past.

A surgical exploration was carried out on January 3, 1946, for appendicitis. The appendix was found to be fibrotic and not inflamed. The gallbladder was found to be dark red in color, extremely enlarged and tense; it was opened and a large quantity of viscid bile and numerous small stones removed. A cholecystostomy was performed and a small section of the wall was removed for biopsy. Microscopic examination revealed acute gangrenous cholecystitis. Postoperative course was uneventful and the patient was discharged.

He was readmitted on February 11, 1946, with a history of acute epigastric and right upper quadrant pain of approximately one week's duration. He also complained of abdominal fullness, vomiting, and frequent loose stools. Examination at this time revealed abdominal distention, hyperactive bowel sounds, tenderness and spasm in the epigastrium and right upper abdomen. Laboratory examinations during this admission were normal. The clinical impression was a paralytic ileus. This painful seizure subsided within two days after admission, but again recurred in a few days, following a meal.

* Resident in Medicine, Indiana University Medical Center, Indianapolis.

On February 26, 1946, the patient returned to the hospital with a history of acute right upper abdominal pain, nausea and vomiting of four days' duration. The pain was intermittent in character and did not radiate. Examination revealed only moderate tenderness in the right upper abdomen. There was no abdominal distention present. Blood pressure was normal and the pulse was 100 per minute. The temperature was normal. The remainder of the physical examination was normal and no jaundice was evident. Urinalysis and blood counts were normal. The direct van den Bergh was reported as positive. Blood sugar was normal. Cholecystograms failed to reveal the gallbladder and no biliary tract stones were noted. Gastrointestinal series revealed 5 percent gastric retention at the end of six hours and an extrinsic pressure defect against the greater curvature portion of the pyloric antrum and the duodenal cap. When the patient was lying prone, a definite pressure narrowing of the descending duodenum was found.

An exploratory laparotomy was performed on March 14, 1946, and revealed the gallbladder to be greatly thickened and adherent to the anterior abdominal wall. The common duct was normal. The stomach was also normal. The pancreas revealed marked enlargement and firmness to the body and tail; the head appeared normal to inspection and palpation. A partial pancreatectomy was performed (body and tail). The surgeon felt that this pancreatic pathology represented carcinoma. Microscopic examination of the resected pancreas revealed extensive fibrosis with decrease in the amount of acinar tissue. A moderately severe inflammatory reaction was evident in the lobule of acini, but was much more evident in the areas between the lobules. The inflammatory infiltration consisted of lymphocytes and plasma cells. The main pancreatic duct and branches showed only a periductal inflammatory reaction. Other sections revealed the same marked inflammatory and fibrotic reactions. In none of the sections examined was there any definite malignant transformation in the duct epithelium or in the acini of the pancreatic material. The pathological diagnosis was chronic pancreatitis and fibrosis of the body and tail.

The patient was followed for one year and during this period he remained entirely free of acute painful seizures. At the end of this follow-up period he failed to return for further appointments.

Case II: A white man, age 69, entered the Medical Center on April 2, 1948, complaining of acute epigastric pain, along with nausea of one week's duration. This acute episode was sudden in onset following an evening meal. The pain and nausea persisted and the patient vomited on one occasion. The past history was not remarkable and he denied food intolerances, colicky abdominal pain, jaundice, chills and fever. Examination revealed a well-developed, obese male who appeared acutely ill, with a slightly ashen skin. Blood pressure was recorded at 110 mm. of mercury systolic and 70 mm. of mercury diastolic. The pulse was 90 per minute and temperature 100° F. The abdomen was markedly distended. Marked tenderness and spasm were elicited in the right epigastrium. Auscultation revealed normal bowel sounds. Rectal examination revealed only moderate enlargement of the prostate gland. Urinalysis and blood counts were normal except for a leukocytosis of 13,850. Nonprotein nitrogen was reported as 51 mgm.% and the serum amylase was 228 mgm.%. Direct van den Bergh—delayed positive and indirect—was 1.37 mgm.%. In view of the severe abdominal distention, the treatment instituted was decompression by Wangensteen suction and parenteral fluids. Within 48 hours the patient was satisfactorily decompressed and his acute epigastric pain had completely subsided. Abdominal examination on April 4, 1948, revealed an equisitely tender mass in the epigastrium measuring approximately 6x8 cm. The mass remained palpable throughout the hospital course.

A survey x-ray of the abdomen revealed a laminated calcific density in the gallbladder region and scattered calcific densities in the region of the pancreas. The survey film failed to reveal any distinctive pattern of the gaseous markings in the bowel. Barium enema and upper gastrointestinal series were entirely negative except for a diverticulum, in the third part of the duodenum. The same calcific densities in the pancreas were observed. Oral cholecystograms did not visualize the gallbladder shadow. A large laminated calculus was present in the region of the fundus of the gallbladder. The patient was discharged on his sixteenth hospital day relatively asymptomatic.

The patient remained free of acute painful seizures until September 22, 1949, at which time he developed acute pain in the epigastrium associated with nausea, vomiting, and frequent loose stools. He denied chills, fever, melena and fatty stools. Examination at this time revealed moderate abdominal distention, moderate epigastric tenderness and spasm to be present. No masses could be felt. Blood pressure was 160 mm. of mercury systolic and 110 mm. of mercury diastolic. Pulse was 110 per minute. Temperature was 101.2° F. This acute painful seizure was approximately seven days in duration. All x-ray examinations, including cholecystograms, revealed the same findings as those noted on the previous admission. Laboratory examinations were essentially normal except for the glucose tolerance test which was definitely diabetic in type. Serum amylase and lipase determinations unfortunately were not performed until after the painful seizure had entirely subsided and were reported as follows: 180 mgm.% and 0.4 cc. of 0.5 N NaOH per cc. respectively. Liver function studies were normal. The patient was discharged asymptomatic on October 14, 1949, and to date has remained free of acute painful seizures.

Case III: A white female, age 34, was hospitalized July 6, 1943, complaining of acute cramp-like abdominal pain of two weeks' duration, along with nausea and vomiting. She also complained of abdominal distention and fullness, and swelling of the flanks of four months' duration. The patient was constipated for approximately one week, but denied melena or bloody stools. The remainder of the history was noncontributory except for profound emotional instability that necessitated "rest cures" on several occasions and an alcoholic history. Examination revealed temperature to be 99°F. Pulse was 90 per minute. Blood pressure was recorded at 145 mm. of mercury systolic, and 90 mm. mercury diastolic. The abdomen was markedly distended, with shifting dullness and a fluid wave. Borborygmus was present. No masses were observed. Rectal examination was negative. The pelvic examination was negative except for slight rectocele and cystocele.

Laboratory examinations revealed a negative urinalysis except for a slight trace of albumen. Hemoglobin was 12.5 grams. The red cells numbered 3,840,000 and a leukocytosis of 15,500 was reported. Barium enema examination failed to reveal any abnormalities.

The patient went to surgery on July 9, 1943, with a preoperative diagnosis of an ovarian cyst, probably malignant. Laparotomy was performed and a large quantity of straw-colored fluid escaped through the incision. Exploration revealed a large mass at the head of the pancreas that was causing

pressure on the portal vein. The mass was considered to be malignant (unfortunately no biopsy specimen was obtained) or inflammatory, and no further surgical procedures were undertaken. The postoperative course was uneventful and the patient was discharged on August 5, 1943, relatively asymptomatic.

The patient was readmitted on October 13, 1943, with a mild painful seizure in the right upper abdomen associated with nausea and vomiting. The episode subsided shortly after admission. Interval history revealed heavy imbibition of alcohol and frequent use of morphine during the preceding 5 years. The history also revealed frequent and persistent attacks of epigastric pain during this period.

The patient was readmitted on May 24, 1948, complaining of severe persistent epigastric pain and abdominal distention. Examination revealed an agitated, emotionally unstable, white female, appearing chronically ill. Abdominal examination revealed moderate distention and a large mass in the right epigastrium. The remainder of the physical examination was not remarkable except for an elevated blood pressure. Systolic was 170 mm. mercury and diastolic was 110 mm. of mercury.

Laboratory examination revealed urine to have a faint trace of albumen, occasional pus cells, and granular casts on one occasion. Hematological studies revealed hemoglobin to average 9 grams and red blood cell counts averaged 3,000,000. Blood chemistry was normal. Serum amylase on June 2 was 1810 mgm.% and 349 mgm.% on June 15 and June 17. Blood sugar determinations on June 1 and June 15 were 88 mgm.% and 86 mgm.% respectively. Serum calcium on June 15 was 8.5 mgm.% and on June 24 was 6.5 mgm.%.

Oral cholecystograms during this admission showed only faint visualization. No biliary tract stones were seen. Multiple calculi were present at the region of the head of the pancreas. A repeat oral cholecystogram revealed a normally functioning gallbladder. Pancreatic calculi localized to the head again were noted. Barium enema examination was negative.

On June 15, 1948, an exploratory laparotomy was performed. A large quantity of free fluid (approximately 3 to 4 liters) was encountered. A mass measuring 4x6 cm. in diameter was found at the head of the pancreas. Palpation of this mass revealed presence of calculi. The body and tail of the pancreas were normal to palpation and inspection. A Whipple type of pancreatectomy was performed, with a choledocho-jejunostomy and pancreato-jejunostomy.

Pathological examination of the pancreas revealed it to be dense, fibrous, and to contain dilated and tortuous radicles of the pancreatic duct. The pancreatic duct contained a calculus 3 mm. in diameter. Microscopic examination of the pancreatic tissue revealed a picture of dense fibrosis and with scattered areas of small discrete islands of pancreatic acini which showed the effects of autolysis. There was no evidence of malignancy in any of the specimens examined.

The patient was discharged on July 5, 1948, still complaining of epigastric pain. She continued to have severe epigastric pain and sought relief frequently by indulging heavily in alcohol. Her psychiatric condition became worse and there was physical evidence of progressive chronic disease.

The patient reentered the hospital on September 17, 1948. Physical examination revealed evidence of marked emaciation, otherwise was not remarkable. While in the hospital she proved to be quite a problem and repeatedly insisted on being given narcotics and barbiturates. The patient left the hospital at the end of six days, unimproved, and has not been seen since.

CLINICAL ANALYSIS OF CASES

This series consists of a total of seven cases of chronic recurrent pancreatitis. Excluded from this series were six cases of chronic pancreatitis confirmed on pathological examination, which also had adenocarcinoma of the pancreas. Two cases of duodenal ulcer penetrating into the pancreas and giving rise to chronic pancreatitis were also excluded from this report.

1. Age and Sex Incidence: The youngest patient was 28 years of age and the oldest 70. The average age was 51 years. There was no difference in the sex incidence noted.

2. Possible Etiologic Factors: Alcohol—There was a history of alcoholism in three cases (43 percent). Other Factors—Food precipitated an attack in two cases. No other etiological factor was evident in the remaining cases.

3. Associated Biliary Tract Disease: There was biliary tract disease present in six cases; however, in one of these cases the associated disease (chronic cholecystitis) developed seven years after the initial onset of the pancreatitis. One patient had a cholecystectomy in 1944 for a diseased gallbladder and another had a cholecystotomy in 1918 with removal of several stones. One patient had an acute gangrenous cholecystitis with cholelithiasis. Two cases had gallbladder disease as evident on cholecystograms; one of these had nonvisualization with a large single calculus noted, while the other had a nonfunctioning gallbladder filled with multiple small stones. Thus, five cases (71 per cent) had associated gallbladder disease which is quite significant. There was no associated liver disease evident in any of the cases.

4. The Painful Seizures: The shortest history of repeated painful seizures was four months, while the longest was 10 years. Four of the patients had attacks over a period of more than five years. The average for the entire series was 4.8 years.

Mode of Onset: In four of the cases the onset was sudden and severe. The onset was gradual and moderate in the remaining cases.

Frequency: There was no typical pattern as regards the frequency of the painful seizure. In some cases they occurred as frequently as every two to four weeks, while in others at monthly or yearly intervals.

Severity: The pain was marked in three cases, moderate in three cases, and mild in one case.

Location: The pain was localized in the majority of the cases to the epigastrium and to the right upper abdomen. Many described the pain as "boring through to the back."

Duration: The average duration of pain in most cases was 3 to 5 days.

5. Associated Symptoms: All patients had nausea and vomiting. Abdominal distention and constipation were frequent complaints. Only one patient complained of diarrhea. Other symptoms were belching, bloating, anorexia, nervousness and restlessness.

6. Physical Findings: All cases had moderate to marked epigastric tenderness. Only in two cases was there a mass palpable, localized to the epigastrium. Ascites was evident to examination in both of the cases where a mass was palpable. Hepatomegaly and splenomegaly were not found in any of the cases. Abdominal distention was present in five of the cases. There was slight jaundice in one case.

7. Laboratory Findings: Test of Islet Function—Glycosuria was found in four cases. It was transient in two of these. Hyperglycemia was found to be present in three of the cases and the glucose tolerance test on these cases revealed a diabetic curve. Two of these cases developed diabetes after the diagnosis of chronic pancreatitis was established. The other case had diabetes for several years prior to the establishment of chronic pancreatitis. It was of interest to note that pancreatic calculi were found in those two cases that developed diabetes after the diagnosis of chronic pancreatitis was established.

Test of Acinar Function—Serum amylase levels were determined in six cases. It was unfortunate that in two of these cases the levels were not determined until after the acute painful seizure had well subsided. Serum amylase was markedly elevated in three cases (1810 mgm.%, 1275 mgm.% and 712 mgm.%) and border-line in one case (228 mgm.%). Serum lipase levels were determined in only two cases and were found to be normal. Two cases had steatorrhea present. Creatorrhea was found in one of these two cases.

8. Roentgenologic Data: Cholecystography was performed in all seven cases. The results have been discussed under Associated Biliary Tract Disease. Pancreatic calculi were present in three cases. One of these cases had diffuse calcification throughout the entire gland. One case had several calculi present in the head and body, while the other had calculi at the head only. Other roentgenological examinations were either negative or noncontributory.

9. Surgical and Pathological Findings: All but one case had some type of surgery performed on the biliary tract sometime during the course of their disease. Four of the cases in this series underwent surgery during their last hospitalization. The surgical findings were that of diffuse enlargement and fibrosis of the pancreas in all four cases. Partial pancreatectomy was performed in two of the cases. The pathological findings on microscopic examination were those of extensive chronic pancreatitis along with dense fibrosis. In one of these resected specimens, a calculus obstructing the pancreatic duct was found.

DISCUSSION

In the light of the previously recorded observations in the relationship of biliary tract disease to chronic recurrent pancreatitis, it is of interest to note that 71 percent of the cases in this report had previous biliary tract disease. The role of overindulgence in alcohol or food in precipitating an acute attack is well known. These precipitating factors were present in many of our cases.

A history of alcoholism has been frequently noted in pancreatic inflammatory disease. Alcohol has been shown to precipitate an attack of pancreatitis and it is important to remember that alcohol is also a stimulant of pancreatic as well as gastric secretion. The relationship of alcoholism to pancreatitis was shown by Myers and Keefer.[2] Carter[3] found markedly elevated serum amylase levels in eleven alcoholic patients with acute abdominal symptoms, four of whom had acute pancreatitis upon surgical exploration. Comfort[1] and his associates reported that alcohol was used in 68 percent of their cases and used heavily in 32 percent. Alcoholism was present in three of the cases in this series, but only in one case did it precipitate an acute painful seizure.

The relationship of biliary tract disease to the etiology of chronic relapsing pancreatitis still remains disputed. Comfort[1] studied twenty-nine cases in which biliary tract disease was not present. This study is significant in that it definitely shows that chronic relapsing pancreatitis does occur independently of biliary tract disease. However, in the majority of recognized cases there is associated biliary tract disease. Usually gallbladder disease, and especially calcareous disease of the gallbladder of long duration, has been demonstrated to be present before the first acute seizure of interstitial pancreatitis occurs. Bockus and Rafensperger[4] stressed the importance of the presence of biliary tract disease in the etiology of acute pancreatitis. In this series, gallbladder disease apparently did play a role in the development of chronic pancreatitis, for 71 percent of the cases had evidence of gallbladder disease. The question that cholecystitis may result secondarily to chronic pancreatitis was raised by Gambill, Comfort and Baggenstoss.[5] One case in this study developed chronic cholecystitis (demonstrated by cholecystogram and surgical exploration) after repeated acute painful seizures over the course of years.

Opie's[6] theory of a common channel in the etiology of acute pancreatitis has many proponents. Popper[7] demonstrated a common channel in 89 percent of his cases of acute pancreatitis. Howard and Jones[8] demonstrated a common channel at the ampulla of Vater in 50 percent of their cases. Rienhoff and Pickerell[9] demonstrated a

common ampulla in 32 percent of the 250 specimens studied. The cause of obstruction in patients who do not have a stone impacted at the ampulla is not entirley clear. Recent experimental work by Lium and Maddock[10] suggests the possibility that excessive stimulation of the vagus could provide complete obstruction to pancreatic secretion by spasm of the pancreatic ducts or sphincter of Oddi, with resultant back flow of the pancreatic secretion into the tissue spaces. Excessive vagal stimulation may be the etiologic or precipitating factor in those cases of chronic relapsing pancreatitis where no obvious biliary tract disease exists. It has been postulated that in these cases the spasm of the ducti or sphincter of Oddi is much more readily produced than in normal subjects.[10] Further studies in the role of the vagus in the etiology of pancreatitis are indicated. The incidence of chronic pancreatitis in those patients who have undergone vagotomy in the recent years should prove to be of interest.

An acute attack of pain usually is the first sign of the disease. However, this attack of pain usually is of little diagnostic value because of the variability in severity, duration, and location. This was true in the majority of the cases seen here. The diagnosis is frequently established if elevated serum amylase levels are detected during a painful attack. There also may be a temporary hyperglycemia and glycosuria evident if sought. These clinical evidences of transitory disturbances of pancreatic function during an acute painful exacerbation confirm the diagnosis of chronic pancreatitis. In the interval between attacks in those cases having no permanent sequelae, it is frequently difficult to diagnose the disease by physical or laboratory methods of examination.

Increased activity of the pancreatic enzymes (amylase and lipase) occurs early in the attack. One can usually detect high levels of the enzymes in a few hours after the onset of pain, and the levels remain elevated throughout the attack. Upon cessation of the attack, the enzyme levels rapidly return to normal. Curiously enough, the activity of both enzymes is not found to be elevated simultaneously. This was noted by Comfort[1] in his cases. No elevation of serum lipase levels was detected in this series. The level of enzyme activity may remain continuously elevated when mild attacks follow one another rapidly or when the activity of the pancreatitis is prolonged over long periods. Maether and Knight[11] observed serum amylase to persist over 300 mgm. percent in 44 percent of their cases in whom no acute symptoms were present. The explanation offered for the persistent elevation of serum amylase is obstruction of the pancreatic ducts which rupture and permit the entrance of the pancreatic enzyme into the lymphatics.

With progressive destruction of pancreatic tissue resulting from repeated acute exacerbations, the enzyme levels no longer rise with the acute attack, indicating that there are an insufficient number of normally functioning acinar cells. Concomitantly, there is also widespread destruction of the islet cells and diabetes results. The external secretions are affected with progressive destruction of the pancreas and steatorrhea and creatorrhea make their appearance. The findings of permanent disturbances of the islet cells and diminished external pancreatic secretion in a patient with a history of repeated acute painful seizures lead readily to the diagnosis of chronic pancreatitis.

Sprague[12] reported the incidence of permanent diabetes in cases of chronic pancreatitis to be approximately 28 percent. In the cases reported here, diabetes developed in three cases (43 percent). It was of interest to note that in two of the patients with pancreatic diabetes, there were pancreatic calculi. Diabetes is said to occur in about 50 percent of all cases of pancreatic calcification.[13] These calcifications are parenchymal and not intraductal calculi. The diabetes may appear even before calcareous pancreatitis develops, but once its appearance is made, extensive irreversible interstitial damage has occurred and one can expect calcification to develop in approximately half of these cases.

Other sequelae of chronic pancreatitis encountered in this series will be presented. Frequently the enlarged head of the pancreas may cause pressure on neighboring structures with resulting physical findings that may confuse the clinician in establishing the correct diagnosis, as occurred several times in the cases observed at this hospital. The head of the pancreas, enlarged by extensive inflammation, may press on the duodenum with partial or complete obstruction, dilatation of the duodenum and stomach, and retention vomiting. Moderate to marked abdominal distention frequently occurred during a painful seizure and resulted in the consideration of intestinal obstruction as the diagnosis. The enlarged pancreas may create pressure defects on the stomach. The common bile duct may be obstructed by the enlarged pancreas with resulting jaundice or secondary disease of the gallbladder. Ascites produced by pressure on the portal vein from an enlarged pancreas may result, as it did in two of the cases in this series.

Weight loss is common in chronic pancreatitis, and especially in those cases with steatorrhea and creatorrhea. Moderate to frank malnutrition is fairly common, and subclinical states of deficiency develop. In chronic pancreatitis, the deficiency states usually do not reach the stage of clinical recognition, nor manifest themselves as does nontropical sprue. This is an important differential point between the steatorrhea of chronic pancreatitis and nontropical sprue.[1] Weakness, fatigue and anxiety states develop, and the pa-

tients become incapacitated, lose stamina. Addiction to alcohol or narcotics results from discouragement, incapacitation and frequent hospitalization. This occurred in two of our cases.

CONCLUSIONS

Chronic pancreatitis is a progressive disease that is characterized by repeated painful seizures separated by variable intervals of relative quiescence. Early in the disease disturbances of function of acinar and islet cells are apparent during the acute exacerbation. As the disease progresses, the disturbances of the pancreatic function become permanent, resulting in diabetes, steatorrhea, and creatorrhea. Calcification of the pancreas results in severe or protracted cases.

Though chronic pancreatitis does occur independently of biliary tract disease, most cases do have an associated cholecystitis and/or cholelithiasis. This associated biliary tract disease appears to have a definite relationship in the production of the chronic pancreatitis, but the exact mechanism is still highly speculative. The possibility of excessive vagal stimulation in production of spasm of the sphincter of Oddi and pancreatic duct remains to be studied further. Excessive indulgence in alcohol and heavy meals are quite important etiological factors in precipitating an acute exacerbation.

The problems of diagnosis of chronic relapsing pancreatitis are indeed many. Chronic recurrent pancreatitis should always be considered in those patients with frequently recurring painful seizures. The diagnosis is readily established by familiarity with the clinical features, by tests of pancreatic function and roentgenologic findings.

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Associate Editor: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana.
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700 STUDENTS—8 MICROSCOPES

NOW THAT WE are about to hear from the chiropractors again, clamoring for their own state licensing board, let us see why they want such a board when the door is already open to licensure in this state, provided they have the same education as everyone else who practices the healing art, namely, six years of training in approved colleges after graduation from high school.

While the chiropractors—and all other drugless practitioners, for that matter—must have the same number of years of training as physicians and osteopaths to be eligible for licensure, they are not required to write an examination in materia medica, and therapeutics, surgery, or obstetrics. Seemingly, then, the only reason for the chiropractors to ask the legislature for a board of their own is to escape the educational requirements which they now fail to meet. The figures quoted below from the A.M.A.'s annual medical licensure report gives a strong and sufficient clue:

> "Among the 4,675 graduates of approved medical schools in the United States, only 3.2 percent failed. Of the 737 graduates of faculties of medicine located in countries other than the United States and Canada, 56.7 percent failed, and of the 114 graduates of schools of osteopathy, 42.1 percent failed. Among the 282 graduates of unapproved schools in the United States, 34.7 percent failed."

Testimony given at a hearing before a commission of the Province of Quebec, Canada, late in 1947 by John J. Nugent, "Director of Studies of the National Association of Chiropractic," from New Haven, Connecticut, stated that the largest school of chiropractic was the one in Los Angeles, with 700 students; that there were 32 "professors," of whom 16 were "full time"; that the school in Chicago had 640 students and 16 full time "professors"; that the Western States College, with 265 students had 8 "professors"; that at the Los Angeles school anatomy was taught in a room 45x35 feet, with work on dissection divided into two groups of 25 each; that this school had 8 miscroscopes for 700 students,—and so on.

How can "graduates" of such "schools" hope to compete in fair examination with men trained in Class A medical schools?

The approved medical colleges of the United States and Canada must provide huge areas for instruction of the basic sciences of anatomy, physiology, biochemistry, pathology, as well as pharmocology and microbiology, the latter two being of little significance in the chiropractic curriculum. Each student must have full access to a microscope along with other expensive items of personal equipment. Ten or more full time professors and instructors are employed in each of the departments listed above. For the clinical years,

four hospital beds as a minimum are needed for each student and a comparable requirement is placed on out-patient service. The principal clinical departments of most medical schools have a nucleus of from six to ten full time teachers and a large number of auxiliary technical personnel. By and large, medical faculties have one full or part time member for each one and one-half students. This number is by no means excessive considering the present-day demands for specialized instruction in nuclear physics, isotope therapy, tropical medicine and children's psychiatry—to name a few, and the modern trend toward small group bedside teaching which is highly effective but costly in staff.

Six years of training has been found to be the minimum for safety to the public, and specialists require much more. Those superficial enough, or unscrupulous enough, to take up chiropractic as a means of livelihood would not be likely candidates for proper medical training. Thus, their only hope of licensure here lies in cutting a back door into the practice of the healing art. Hence, we have the biennial struggle in the legislature. We expect it, and we must always be prepared to meet it. Each member of our association must stand ready to do his bit, if called upon.

THE MOST IMPORTANT VOTE

THAT most important single vote is YOURS. American history is full of instances in which there has existed a sharp difference of opinion on national issues and on the election of officials. More often than not these differences have been settled by a relatively few votes, and in several famous instances by one vote.

Almost without exception elections, even those popularly known as "landslides," could have been reversed by that portion of the electorate who stayed at home on election day.

It would be difficult to imagine circumstances which would present more vital issues than those which confront the citizens of this country today. We have suddenly found ourselves to be citizens of the world, and whether we seek the world's responsibilities or not, those responsibilities and the decisions which they entail are ours to deal with.

The approaching elections are providing issues which are worthy of the most solemn consideration on the part of each citizen. The results may well determine our way of life for many years to come. Each one of us as an American has an obligation to vote and to do all in his power to encourage others to do likewise.

The only wrong vote is the one that is not cast.

MEDICAL CARE NOT SO COSTLY

COMPARATIVELY speaking, the cost of medical care has not risen as fast as has the cost of other necessities.

Each year the A.M.A. Bureau of Medical Economic Research analyzes data from the U. S. Department of Labor in order to determine the relative changes in the cost of sickness. The period from 1935 to 1939 is used as a base period.

Since 1943 each year's tabulation has shown a slower increase in medical costs than has been shown for the cost of living. Figures recently released for 1949 demonstrate a continuation of this pattern.

Last year the cost of living was up 69 percent as compared with 1935-39, while the expenditure for total medical care was increased by only 45 percent.

Drugs (up 23 percent) and physician's fees (up 37 to 38 percent) were the two items which exhibited the least increase. Hospitals, however, subjected as they are to the inflationary spiral of costs of goods and services, have increased their per diem expenditures by 127 percent over the base period. However, when the shortened hospital stay is considered (12.5 days to 9.2 days), the relative increase in the cost of one hospital admission is up only 67 percent, approximately equal to the percentage increase in the cost of living.

There is another factor which should be considered in the economic cost of illness. For a wage earner, time away from work is as important financially as is the time spent in the hospital. Speedy recovery and early return to work contribute much to the lowering of the cost of sickness. If some of the increases in hospital costs are making it possible to restore a patient's earning ability more quickly, then these increases may be considered as money well spent.

During the past ten years there have been several innovations in the hospital care of seriously ill patients. These include the increased use of blood transfusion, the increased use of oxygen, refinements in the technique of anesthesiology, and the introduction of antibiotic and new endocrine drugs. These innovations have some common characteristics.

First, they are expensive; at least they are more expensive per day than the older and more standard agents. They contribute considerably to the cost of hospitalization.

Secondly, they are tremendously effective. They reduce mortality rates. They enable a patient to leave the hospital sooner, and they also enable him to return to work sooner.

These innovations, together with less expensive modern aids to treatment, help to accomplish a cure in a short time. Twenty years ago serious

illness, if it did not terminate fatally, was followed by a protracted convalescence. Today fatalities have been markedly decreased, and recoveries are speedier.

Today a patient with a lobar pneumonia, caused by an organism sensitive to an antibiotic, can scarcely be considered to be ill after the first two or three days. He has recovered and is back at work almost before a similar patient twenty years ago would have been able to leave the hospital.

The modern patient's day-by-day hospital bill is higher, but he will not be hospitalized as long, and better still he will be able to re-establish his income much sooner. It is possible that when the factor of early return to work is considered the relative cost of hospital care may be much lower.

DR. MAX A. BAHR

DR. MAX A. BAHR, superintendent of Central State Hospital, has been honored by appointment to the executive committee of a proposed new national association for the study of mental disease. The new organization will be known as the National Association for Mental Health. It will combine three mental health bodies, the National Committee for Mental Hygiene, the National Mental Health Council and the Psychiatric Foundation.

The proposed merger has been hailed as a progressive step, since each of the three groups was originally organized with the same general aims, and since they have been traveling parallel courses in recent years. Each of these organizations is now working separately for improvements in prevention and treatment of mental disorders. A single unified program will make possible many economies in effort and finance.

Doctor Bahr has now been connected with Central State Hospital in one capacity or another for fifty-two years. He is in his twenty-seventh year as superintendent, and has for a long time been referred to as the dean of superintendents of our state institutions. The hospital, under his direction, has pioneered in the treatment of mental disease.

Indiana is proud of this recognition of Doctor Bahr's talents. Doctors the state over are offering their congratulations, and at the same time will be wishing Godspeed to the newly organized National Association for Mental Health.

Letter to the Editor

SOME EXPERIENCES IN A STATE MENTAL INSTITUTION

In August, 1947, after having practiced some fifteen years in northern Indiana in a small resort town, where practice was so heavy that it was felt my health would not stand up too long, the writer decided to try practice in a mental institution. Accordingly, on August 15, 1947, we arrived at the Richmond State Hospital. Upon arrival I found the superintendent had resigned as of that date, and an acting superintendent had been sent out from the Indiana Council of Mental Health. As a result, there was no one to tell me anything as to what was required to take care of mental patients, so what little I have learned has been in a sort of hit or miss fashion. I am free to confess I knew nothing of mental illness, and scarcely knew how to spell psychiatry. Having graduated from medical school when psychiatrists were considered somewhat as freaks, scarcely any training was given to this type of work.

During my service here I have acted as an assistant physician, acting assistant superintendent, acting superintendent, and for the past ten months back to assistant physician. During this period the number of physicians on the staff has fluctuated from three to seven and is now back to three again, excluding the superintendent.

My duties consist of looking after the welfare of some nine hundred women patients, and also about eighty men on receiving unit, and disturbed ward; also those who are to receive acute treatment, such as electroshock therapy and hydrotherapy; also taking care of correspondence from relatives regarding those patients, and attempting to evaluate the mental condition of these patients, to determine which patients should be presented to staff for possible furlough. So you can readily see I have not retired.

It should be mentioned also that mental patients also become physically ill. We see the same type of ailments among these unfortunate people that are seen in a private practice and nothing is more gratifying to the physician than to see a patient, no matter how delusional, hallucinated or disturbed, express his pleasure at having been relieved of a physical ailment. I recall one of our most disturbed patients who recently developed a severe and painful localized infection of his leg. After the writer had lanced the leg, his "Thanks, Doc" was very satisfying.

Another satisfying experience is to have some patient admitted in a very acute mental condition

(Continued on page 1024)

President's Page

OUR TOMORROW

IT HAD BEEN my hope to write my first President's Page in an informal and casual style. Then I began to realize that we in America have been much too casual for the last twenty years. During this period we have seen a profound change come over our country. We have seen acceleration of Federal spending until national bankruptcy threatens us. In recorded history no Democracy has survived prolonged government spending. We have seen unprecedented concentration of bureaucratic power in Washington. There are some elected representatives who think more of the next election than they do of the next generation. These are politicians, as distinguished from statesmen. They pose as the champions of the "common man" while at the same time they rob him of his freedoms and his possessions. Big government means little citizens.

The spiritual, intellectual and economic vigor which made America great is waning. Living through an age of unparalleled prosperity has spotlighted our human weaknesses. We must realize that civilization cannot survive materially unless it is redeemed spiritually. This is the challenge to our churches, to our schools, to our political organizations and to everyone who fears God or loves his country.

If America fails, our efforts to preserve free medicine will not mean much. Are there enough real patriots left who want the old America back and who are willing to work for it? America was not founded by weaklings and it cannot be preserved by them. We owe it to America and especially to the children of America, to take an active interest in the coming election, because in a Democracy we dare not take our liberties for granted. We must remember on November 7 that we will get only the kind of government we are willing to work for. America CAN be salvaged if YOU will work for it. Each one of us should ask himself, "Do I deserve good government?" Do you?

Alfred Edison

ALFRED ELLISON, M.D.

South Bend

PRESIDENT

INDIANA STATE MEDICAL ASSOCIATION

1950-51

ALFRED ELLISON, M.D.

President
Indiana State Medical Association
1950-51

DR. ALFRED ELLISON, of South Bend, inaugurated his term as president of the Indiana State Medical Association at the conclusion of the annual convention in French Lick on September 27, 1950.

As Doctor Ellison received the gavel, emblematic of the duties and responsibilities of this high office, from the retiring president, Dr. Claude S. Black, he announced that his watchword for the coming year was to be "Americanism."

This is an exceedingly appropriate motif for our association and for our president during this coming year. Americans are the only large group of people in this world who are blessed with the advantages which have accrued from the free and unregimented practice of medicine. Proposed socialistic controls are of foreign origin and are entirely un-American.

Doctor Ellison, during recent years, has been one of our most effective leaders in the medical profession's fight against those forces which strive to control the practice of medicine, and unwittingly to deteriorate the standards of medical care. He is wise in reminding us that the antidote for un-American activities is "Americanism."

Doctor Ellison was born at Anderson, Indiana, on July 9, 1896. He was educated in a one-room rural school and then graduated from Anderson High School in 1914. After attending Indiana University for three years, he served for eighteen months in the U. S. Army, with twelve months of overseas duty. He received his M.D. degree from Indiana University in 1924.

After an eighteen-months' internship at the Indianapolis City Hospital, he established a general practice in South Bend. In 1930 he entered a three-year graduate course in surgery at the University of Pennsylvania, from which he received the degree of Master of Medical Science.

Since 1933 he has practiced general surgery in South Bend, and is now chief of the surgical staff of Memorial Hospital. He is a Fellow of the American College of Surgeons, and a diplomate of the American Board of Surgery.

He married Olive Elaine Malcolmson of Anderson, on August 25, 1925.

Doctor Ellison's long list of services to his county, district and state medical societies is a testimonial to his qualifications for the office of president of the state association. He was president of the St. Joseph County Medical Society in 1933-34. He served as secretary of the Thirteenth District Medical Society in 1934 and 1935, and was Councilor from the Thirteenth District from 1939 to 1949. From 1947 to 1949 he was chairman of the Council, which also made him a member of the Executive Committee and the Budget Committee.

He has also served as a director of Mutual Medical Insurance, Inc., for three years. He has been a member of the Advisory Board of the State Welfare Committee, and was a member of the Committee to Study Cultists and Irregular Practitioners in 1938, and was chairman of this committee from 1939 to 1943. He has been a member of the Committee on Industrial Health, the Medical Relief Committee, the Indiana Inter-Professional Health Council, and the Committee on Medical and Nursing School Scholarships.

"Judge," as he is known by his many friends, enters his year as president with a splendid record of service to the medical profession, and with the confidence and good will of the entire membership.

DOLLARS FOR RETIREMENT

A report by Elton R. Clarke, M.D., Chairman of a committee appointed to study the retirement problems of members of the Indiana State Medical Association

"IN THIS ERA of high taxes, high cost of living and low yield on investments, it is extremely difficult for the average individual to save enough out of personal earnings to solve his retirement problem," a prominent bank official recently stated. Doubtless the impact of these factors on the problem of our members accumulating money for their own retirement prompted the Council of the Indiana State Medical Associa- appoint a committee to study the retirement problem of its members.

Through this study the committee has become more keenly aware of the existence of the problem. Our study of the yield on investments and income taxes shows conclusively that not only has the yield been reduced, but that the yield, when subjected to income taxes, is susbtantially reduced. The net take-home investment income amounts to approximately one-half that which was available ten to fifteen years ago. The significance of the problem is shown by the following table:

THE AMOUNT LEFT OF EACH DOLLAR OF ADDED INCOME AFTER TAXES

If Taxable Net Income is	$4,000	$8,000	$12,000	$20,000	$30,000
Amount Left After Taxes	80.6c	77.12c	73.96c	66.96c	58.6c

The above is based on split income return and neither state nor local taxes have been considered.

In view of the above, your committee felt that any plan which could keep the yield on investments from becoming subject to income taxes would be of tremendous value in the accumulation of money with which to solve the retirement problem. Eliminating unnecessary taxes in this way is an important objective of THE INDEPENDENCE PLAN recommended by the committee.

The personal investment experience of many members of our association indicates the necessity of avoiding unnecessary investment hazards. As busy practitioners, we seldom have the time or opportunity to keep ourselves informed on investments to the place where we can, with confidence, manage an investment program that will assure freedom from investment worries. It was the thought of your committee that a plan which would give to members of our association the broad experience available under a group investment principle would free them from investment worries, both during the years of their active practice as well as at retirement.

One of the problems which has confronted many practitioners has been that they have been able to start good investment programs and keep them in force during those years when incomes were good and then have them fall by the way in a year when practice was not so good. Doubtless thousands of dollars of savings have been lost by our members in this way. Your committee believes that any good investment program must provide that maximum flexibility which would permit larger investments in good years of practice and smaller amounts in those made in years when income is not so good. This is one of the unusual advantages in THE INDEPENDENCE PLAN.

The increasing longevity of our own members is illustrative of that of the people in general in this country. It is interesting to note that approximately 36 percent of our members have either attained the normal retirement age of sixty-five or are within ten years of it. In this country approximately 2,700 people are daily attaining the age of sixty-five. Because of the natural increase in longevity, insurance companies have found it necessary to increase annuity rates from time to time over the past few years and doubtless will be forced to do so many times again in the future. If our members could today guarantee the favorable rates at which they may choose to buy retirement annuities when and if they do retire, it doubtless would save thousands of dollars for them. This guarantee is available through THE INDEPENDENCE PLAN.

In addition to increasing the retirement fund of our members through the many advantages of THE INDEPENDENCE PLAN, it is interesting to note that the same plan has liberal provisions by which to increase the value of the estate to the descendants of the participants in the Plan.

THE INDEPENDENCE PLAN will increase the value of your estate by providing, on an unusually liberal basis, a family pension death benefit payable either before or after retirement. This family pension death benefit has been perfected to decrease estate cost to the irreducible minimum, providing the largest possible income to the beneficiary, and doing so on a guaranteed basis.

The details of this Plan have now been worked out and will be presented fully to each member of the association who is interested in the Plan. Because of the tremendous value of the Plan to each of our members, we are sure that it will be given full consideration.

A.M.A. CLINICAL SESSION

THE FOURTH CLINICAL SESSION of the American Medical Association, designed primarily for the general practitioner, will be held in Cleveland, December 5-8.

The scientific sessions and the scientific and technical exhibits will be presented in the Cleveland Municipal Auditorium. Meetings of the House of Delegates will be held in the Statler Hotel. These sessions of the body elected to govern the affairs of the A.M.A. are attracting more and more non-delegate physicians each year.

Outstanding clinical teachers with recognized ability as speakers will headline the scientific demonstrations. Actual cases will be presented and discussed. Diagnoses, treatment and preventive measures as they fit into daily practice will receive the greatest attention.

Each clinical session will be limited to an attendance of 100 physicians. These small groups will make it possible for the general practitioner to enter actively into the discussion and to inquire about his own cases. Leading men in each of the fields under discussion will be available to help with the problems presented.

In obstetrics, difficult cases of interest will be featured. Especially stressed will be the general subjects of breech deliveries, induction of labor, indications for cesarean section, obstetric analgesia and anesthesia, and hemorrhages.

Clinical discussions featuring actual pediatrics patients have been programmed. The care of premature infants, acute diarrhea in children, rheumatic fever, preventive medical measures and psychiatric care for small children are among the interesting topics scheduled.

Because of the unusual interest displayed last year in the section devoted to management of heart cases, there will be a similar session this year. It will include discussions on hypertension, recent advances in drug therapy, including ACTH as it applies to heart disease, acute arterial occlusion and cardiac arrhythmias.

Of special interest will be discussions on Parkinsonism, the use of the electroencephalograph, electric shock therapy and psychotherapy.

With more cases of fluid balance appearing because of the larger number of geriatric patients, there will be discussions on fluid replacement in shock, renal repairment, dehydration and other topics.

Of unusual interest will be the new studies and clinical histories involving traumatic surgery. This will include material on reconstructive surgery, emergency analgesia and emergency surgical measures.

Taken up in detail will be the management of postoperative or inoperable cancer patients. The use of analgesics and the effects of hormone and radiological treatment will be discussed.

An excellent program has been arranged covering diabetes. This will include diagnosis, vascular complications, special consideration in pregnancy and surgery, and dietary problems.

Very timely will be the panel discussions and demonstrations on the diagnosis of poliomyelitis, the treatment of respiratory failure and the management of paralytic cases. There will be demonstrations of physical therapy and rehabilitation measures for poliomyelitis cases.

Papers covering practical problems in dermatology and syphilology will be presented. Deep fungous infections and industrial, allergic and contact dermatoses will be demonstrated and discussed. Emphasis will be put on the newest developments in syphilology.

New developments and refinements of older techniques will feature the discussions on anesthesiology. Spinal anesthesia, management of the surgical case, intravenous administration and other practical problems will be reviewed.

Outstanding speakers will discuss ulcers, jaundice, infectious hepatitis, cirrhosis and other gastrointestinal diseases. Newest advances in medicine and the use of many newer drugs and their application to the general practice of medicine will be presented in another section. Of special interest will be the discussions on the use of antibiotics, hormones and antispasmodics.

Outstanding features of the scientific exhibits will be special demonstrations on fractures, diabetes, rheumatism and arthritis. Exhibits will be presented on cancer, pediatrics, chest diseases, surgical procedures and other subjects correlated with the clinical presentations.

Once again color television will take its place on the program. A schedule of surgery, clinical treatment and examination will be telecast from the Western Reserve School of Medicine to the auditorium. It will be sponsored by Smith, Kline & French Laboratories.

The annual General Practitioner Award has come to be regarded as one of medicine's highest honors and a definite step toward increasing the recognition of the family doctor. This year's selection will be made at the Cleveland meeting.

The steadily climbing registration of general practitioners at the clinical sessions and the comments of those participating indicate these meetings are valuable means of keeping abreast of developments in medicine. It is hoped that a record number of physicians will take advantage of the opportunity in December to attend. The program has been designed with that in mind.

AMBULANCE PLANES AVAILABLE IN INDIANA

The Civil Aeronautics Administration, Department of Commerce, has compiled a directory of ambulance planes for the benefit of physicians and hospitals. The Indiana list of planes follows:

ANDERSON
Anderson Charter & Flying Service
Ace Airport
(D) 2-1200 (N) 8772
Cessna 170; S D or N

ELWOOD
D. G. Flying Service
Elwood Airport
(D) 87 (N) 1843
Aeronca Sedan; S D or N

EVANSVILLE
Crescent City Aviation
Municipal Airport
(D) 3-8448 (N) 6-2904 & 5-9938
Cessna T-50; S D N

Stinson Station Wagon S D N
Sky Service Corporation
Municipal Airport
(D) 3-6201 (N) 3-6201 & 3-8420 & 6-1203
Cessna 195; S D N O

INDIANAPOLIS
Air Sales & Service, Inc.
Weir Cook Municipal Airport
(D) BElmont 3309 (N) IMperial 0584
Ryan Navion; S D N

Indianapolis Flying Service, Inc.
Weir Cook Municipal Airport
(D) BElmont 2770 (N) HUmbolt 1143
Cessna T-50 Twin; S D N O

Roscoe Turner Aero Corp.
Weir Cook Airport
(D) (N) BElmont 2401
Beechcraft D-18-S; 2S 3D O
Beechcraft Bonanza; S D O
Stinson Reliant; S D O

KOKOMO
Ruzicka Flying Service
Ruzicka Airport
(D) 7556 (N) 22534
Stinson Station Wagon; S N

LAFAYETTE
Halsmer Flying Service
Halsmer Airport
(D) 45530 (N) 41530 & 41531
Aeronca Sedan; S D or N O

W. LAFAYETTE
Purdue Aero Corp.
Purdue University Airport
(D) 2400 (N) 83461
Beechcraft 18-S Twin; D N (total 3)

MUNCIE
Muncie Airport
Muncie Airport
(D) (N) 22236
Stinson Station Wagon; S D or N O

EXPLANATION OF INFORMATION AND SYMBOLS

First line—Name of city or town
Second line—Name of agency providing ambulance service
Third line—Name of airport where agency is located
Fourth line—Telephone number(s) of agency:
(D) during daytime
(N) at night.
Fifth line—Type(s) of aircraft used; and symbols indicating the services available:
S—stretcher
D—doctor
N—nurse
O—oxygen

(Continued from page 1018)

and in a few months be able to return and adjust to life outside an institution.

The writer's purpose in these rambling remarks is to try to convince a few physicians of Indiana that a general practitioner can contribute to state mental institutions. They need not know psychiatry, although to be successful they must practice it every day in general practice, even though they may not realize it. A little kindness, a little understanding, a little knowledge of human relations, will go a long way with mental patients. We do need psychiatrists, but until we are able to train more, we also need general physicians.

If we could obtain two or three more physicians here, as well as at the other state mental institutions, much more could be done than is being done. Any physician between the age of fifty to sixty-five who does not wish to retire, and yet feels that his general practice is getting too burdensome for him, might well consider this type of work. The pay is not too great, but is still a good living wage, and the feeling that you are doing your bit for an unfortunate group of people is the greatest recompense one can have.

Leslie A. Laird, M.D.

Medical Panorama by the Associate Editor

MORE AMMO FOR THE GOOD FIGHT

OCCASIONALLY, even in the year 1950 A.D., a little good news seeps through the thick blanket of pessimism, defeatism, socialism and general disgruntlement under which we squirm—a little oxygen to quicken our enfeebled metabolism. We refer to one of the "arguments" of the socio-political do-gooders in support of socialized medicine, in which they point to the dearth of doctors in this country, and state that such lack is in a state of arithmetical (or is it geometrical?) progression: i.e., progression backwards.

However, as often happens, when we dig into the true state of affairs instead of reiterating old statements, a different picture meets the statistical eye, as witnessed by the following excerpt from an A.M.A. news release concerning its new directory:

> Nearly two out of every three physicians in private practice in this country are family doctors.
>
> This is brought out by the American Medical Association's recent count of physicians in connection with its publication of the 18th edition of the American Medical Directory, according to Frank V. Cargill, Chicago, directory editor.
>
> The new directory shows that the physicians of the United States are in the following classifications: 72,550 are in general practice and 22,976 are in general practice but give some attention to a specialty; 54,891 limit their practice to a specialty: 12,536 are in federal government service; 9,700 are retired or in fields not related to medicine; 3,737 are in administrative, editorial or other executive positions related to medicine, and 24,887 are interns, resident physicians or full time physicians in hospitals.
>
> The previous directory, issued in 1942, listed the number of physicians in the United States as 180,496. In the 1950 edition the number is 201,277, an increase of 20,781 and an average yearly gain of 2,598 during the last eight years.

Surely an average annual gain of nearly 2,600 is not to be sneered at. Allowing 12½ percent deduction for those who enter fields, such as federal government service, research, administration, etc., which remove them from availability to the general public, we still have about 2,275 more doctors every year than we had the year before.

It begins to look as if this were one more area of American life where the people are being "panicked" into receptivity for the ideas of our socio-political planners. The technique is becoming as characteristic and as deceptive as certain other "lines" we have heard about. The shade may be different, but the primary color is the same. We trust the above-mentioned statistics will make live ammunition in our fight for public esteem in support of medical freedom.

P. S. Do you suppose your Congressman would be interested in these figures?

THE MATTER OF PRIVACY

The Journal of the Medical Society of New Jersey calls our attention to a tendency among the profession to be a bit lax in the matter of privacy. In its August, 1950, number is a most interesting editorial, all of it good, but only part can be quoted:

> Privacy in some respects is an old fashioned virtue . . . A child has a personnel folder in the school building and in it are facts about his vaccination, his I.Q. and his relations with his parents. And this grows with each year of school. When he seeks employment another file appears in which are entered his height and weight and his scars and his aptitude test scores. In the Army a new and even bigger file is created. If he seeks government employment (and millions of us do) the insatiable folder accumulates data about his chest x-ray and his loyalty and his medical history.
>
> * * * *
>
> One can scarcely blame the doctor for feeling that privacy is a lost pleasure, for how can there be privacy when a hundred file cabinets contain all sorts of intimate data about you and me? Within each agency's framework, the privacy of the file cabinet is, no doubt, scrupulously preserved. But when ten clerks have access to each cabinet, and a hundred cabinets contain our folders, then a thousand persons can pull us out of hiding and read the score aloud. Privacy is for prudes, it appears. Why keep quiet about Mr. X's tuberculosis when it is known to the orderly in the plant infirmary, to the attendant in the chest clinic, to the adjuster, the agent, the clerk and the attorney in the office of his health insurance company and when it appears on his application for cash sickness benefits?
>
> In spite of the increasing transparency of life's goldfish bowl, the clergy as a group valiantly maintain their respect for the confidence of the penitent. We of the medical profession can, with little effort, do likewise. It does not take a large measure of self discipline to keep the mouth firmly closed when there is an urge to boast about the important patient or to clothe with reality the fascinating case history. One of our arguments about state medicine is that it may well destroy the confidence of doctor-to-patient relationships. Even today, under voluntary health insurance, we have to tell the insurance company something of the patient's private life if he is to get his insurance benefits. But let's keep it between us and the insurance company. Before we point a finger of scorn at the leaking ship of state medicine, let's plug some of our own leaks.
>
> Had an interesting case the other day. This man owns that big hardware store down on Elm Street and. . . .

See what he means?

A.M.A. WASHINGTON OFFICE NEWS

New Enlisted Reserve Calls Mean Several Hundred More Physicians for Army. Army's physician requirements for the next three months already are *about 50 percent higher than on August 11*, when it started calling up 734 reserves on mandatory orders. Responsible for the increase are two additional calls for enlisted personnel, 50,000 through Selective Service in November and 47,000 unorganized reserves by the middle of that month. Neither of these totals was included in calculations when Army issued its first quotas for reserves. Although no physician-troop ratio can be applied with much accuracy, *it is estimated that between 300 and 400 more doctors will be needed to care for the additional 97,000 men.* Army has not announced when or in what order it will call up physicians to fill this requirement.

Army Points Toward More Efficient Use of Medical Personnel. In an attempt to cut down on the number of reserves to be called, Army is reducing its *non-military patient load*, recruiting more *civilian* physicians and putting more *efficient* policies into effect. One step is the decision not to accept more VA patients in Army hospitals, a restriction which will be extended to Navy hospitals in the near future. Another is an appeal to civilian physicians to accept contracts for non-military duty in Japan and Okinawa, at salaries ranging from $6,400 to $11,000. Army is also refusing to accept reserve volunteers for one year of active duty, and *requiring them to agree to 21 months.* More important for men who are or will be in service, Army has laid down new rules which it hopes will prevent waste of military manpower in preliminary stages of mobilization. Two examples: Although an infantry division is authorized 42 physicians, only 17 will be retained by it during training period; remainder will be assigned to hospital serving the division for this period. In the case of 1,000-bed general hospital, only three physicians and two nurses will initially be called; balance will stay in civilian life until receipt of warning orders for hospital's deployment.

Civilian vs. Military Physician Distribution Is Issue at Hearings. Senate hearings on doctor-draft legislation (S. 4029) disclosed a widespread interest in the question of what agency if any should be given authority to allocate physicians on a civilian-military basis. At present no agency has authority in this field. National Security Resources Board has a blanket assignment covering all resources, physical as well as human, *but only for planning purposes;* it was created to advise the President, and has no operating authority. Almost every witness at the hearing touched on the question of civilian-military ratios in one way or another. A.M.A.'s witnesses emphasized that some determination should be made, but did not recommend giving the responsibility to any one agency. The PHS Surgeon General recognized the problem, but favored no immediate change in statutory authority. American Dental Association's president, however, recommended that NSRB be given operating authority, including the right to opportion physicians.

Committee Met August 30 on New Aid to Medical Education Bill. House Interstate and Foreign Commerce Committee met in executive session August 30, to consider still another aid-to-medical-education bill, introduced by Rep. Andrew Biemiller (D.-Wis.). In a new approach to the question, this bill proposes $15,000,000 annually for the next five years to be used exclusively for construction and equipment grants. Grants would go directly to the institutions, with states not involved. Federal contributions would be limited to 50 percent, and a National Council on Education for Health Professions would advise but not direct the Surgeon General in administration of the act. Schools of nursing, public health and dentistry also would be eligible for grants. A one-year study of health education needs also is provided. In two recent actions the committee rejected bills which called for scholarships as well as construction grants, in each case by a one-vote margin.

House Committee Drops Science Foundation Appropriation. Because in its opinion the National Science Foundation "will not provide early aid to our defense effort," the House Appropriations Committee rejected a request for $475,000 to start the organization on its way. (Members of the Committee said, however, that they did not want their action to be considered as critical of the Foundation's objectives.) If the cut is sustained, *little progress can be made toward establishing a Foundation until the next Congress meets.* While the White House is understood to be making up a list of 24 nominees to the Foundation, in the absence of appropriations they would have to serve without compensation. The Foundation, supported by A.M.A., was authorized by Public Law 507, signed May 10.

News Notes

POSTGRADUATE COURSE IN OBSTETRICS AND GYNECOLOGY

An intensive, five-day postgraduate course in obstetrics and gynecology will be presented by the staff of the **Indiana University School of Medicine** Monday through Friday, November 6 through 10, 1950, at the Indiana University Medical Center. Attendance is limited to twenty-five; registration fee is $50.00. Address inquiries to the Recorder's Office, Indiana University School of Medicine, 1040 West Michigan Street, Indianapolis 7.

BRAYTON FOUNDATION MEETING

The Alembert Winthrop Brayton Skin and Cancer Foundation will meet at Indianapolis General Hospital on October 19, when Dr. Frederick M. Jacob, Associate Professor of Dermato-Syphilology at the Pittsburgh University Medical School, will preside. During the first hour, from 8:30 to 9:30 a.m., a paper will be presented, followed by a viewing of cases in the skin clinic and a discussion of the cases.

AMERICAN COLLEGE OF PHYSICIANS POSTGRADUATE COURSES

The American College of Physicians postgraduate courses are open to nonmembers with adequate preliminary training, as well as to ACP members. The fee to nonmembers is $60.00.

Course No. 3 will be on critical problems in internal medicine, October 23 to 27, 1950, at the University of Chicago School of Medicine, in Chicago.

Course No. 4 will be on clinical allergy, October 23 to November 3, at Roosevelt Hospital, The Institute of Allergy, 428 West 59th Street, New York City.

Course No. 5 will be on recent developments in medicine, November 6 to 11, at the University of Utah College of Medicine, Salt Lake City, Utah.

For further information, address E. R. Loveland, Executive Secretary, 4200 Pine Street, Philadelphia 4.

SECTIONAL MEETING OF THE AMERICAN COLLEGE OF SURGEONS

The American College of Surgeons will conduct a Sectional Meeting for twelve mid-western and southern states on January 22 and 23, 1951, in St. Louis. A full two-day program has been arranged and an extra day of operative clinics will be planned. The program will be conducted at the Hotel Statler. All physicians, whether members of the College or not, are invited to attend.

POSTGRADUATE COURSE IN CLINICAL GROSS ANATOMY

The Indiana University School of Medicine conducts a postgraduate course in clinical gross anatomy for its residents and other doctors who are interested in postgraduate study. The class meets for three hours one night a week during the regular academic school year. A few places are open each year for which practicing physicians may make application. University credit is given for the course if successfully completed. Further information regarding the fees and exact schedule may be obtained by addressing the office of the assistant dean, Indiana University School of Medicine, Indianapolis.

RESIDENCIES IN OTOLARYNGOLOGY

The **Indiana University Medical Center** announces that two residencies in otolaryngology are available at the Indiana University hospitals. Any physician who is interested is requested to contact Dr. Donald J. Caseley, medical director, Indiana University Medical Center, Indianapolis 7.

POSTGRADUATE COURSES IN CHEST DISEASES

The American College of Chest Physicians announces that it will sponsor two Postgraduate courses in "Recent Advances in Diseases of the Chest." The first postgraduate course will be held at the St. Clair Hotel, Chicago, Illinois, October 16-20, 1950. The second postgraduate course will be held at the Hotel New Yorker, New York City, November 13-18, 1950. Tuition for each course is $50.00. Address all inquiries to the Council on Postgraduate Medical Education, 500 North Dearborn Street, Chicago 10, Illinois.

CASH PRIZE AWARD

The Board of Regents of the **American College of Chest Physicians** offers a cash prize award of $250.00 to be given annually for the best original contribution, preferably by a young investigator, on any phase relating to chest disease. The winning contribution will be selected by a board of impartial judges and the award, together with a certificate of merit, will be made at the forthcoming annual meeting of the College to be held in Atlantic City, New Jersey, June 7-10, 1951. Full information may be obtained by addressing The Executive Office of the College, 500 North Dearborn Street, Chicago 10, Illinois.

NEW FIFTY YEAR CLUB MEMBERS

Twenty-nine physicians became new members of the "Fifty Year Club" this year. Pins and certificates were presented to them at special services honoring them at the annual banquet of the Indiana State Medical Association's state convention in French Lick. The total membership of the "Fifty Year Club" now is 306. The new members this year are:

Clifford E. Canaday, New Castle; A. G. W. Childs, Madison; Walter N. Culmer, Bloomington; Charles R. Dancer, Ft. Wayne; George R. Daniels, Marion; Hardin S. Dome, Tell City; William N. DuVall, Mishawaka; C. D. Ehrman, Rockport; Charles M. Gibbs, Greenfield; William L. Green, Pekin; Joseph M. Heberer, Evansville; Otis C. Higgins, Lebanon; George H. Kamman, Seymour; Henry Lohrmann, Indianapolis; John R. Love, Terre Haute; William F. Morris, Princeton; Lindsey Morrison, Hammond; Harry S. Osborne, Roachdale; Melvin D. Price, Nappanee; Marcus Ravdin, Evansville; D. Monroe Reynolds, Garrett; Alexander G. Schlieker, Spencer; J. W. Shafer, Lafayette; Charles E. Thomas, Leesburg; E. C. Totten, Madison; George R. Tubbs, Lafayette; Ira M. Washburn, Rensselaer; Elmer D. Wright, Seymour; J. R. Yung, Terre Haute.

Dr. Seymour Fisher, previously chief of professional services at the VA hospital in Fort Benjamin Harrison, Indiana, will assume duties of manager and chief of professional services at the Phoenix, Arizona, VA hospital.

The National Gastroenterological Association will hold its Fifteenth Annual Convention and Scientific Sessions at the Hotel Statler in New York City on October 9-11, 1950.

Among the outstanding speakers to present papers at the Convention are: Dr. Richard B. Cattell, Lahey Clinic, Boston, Mass.; Dr. W. Stuart Harrington, Mayo Clinic, Rochester, Minn.; Dr. W. J. Merle Scott, Rochester N. Y.; Dr. John B. O'Donoghue, Chicago, Ill.; Dr. Maurice Feldman, Baltimore, Md.; Dr. Edward T. Lewison, Baltimore, Md.

At the Annual Banquet of the Association to be held at the Hotel Statler on Tuesday evening, October 10, 1950, the winner of the National Gastroenterological Association 1950 Prize Award Contest for the best unpublished contribution on Gastroenterology and allied subjects, will receive the prize of $100.00 and a Certificate of Merit.

Immediately following the Convention, the Association is conducting a Course in Postgraduate Gastroenterology at the Hotel Statler in New York City on October 12-14, 1950.

Further information concerning the program and details of the course may be obtained by writing to the Secretary, National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

ISMA SCHOLARSHIPS

The Indiana State Medical Association has awarded $500-a-year scholarships to Charles E. Gunnoe, 276 South LaSalle Street, Indianapolis, and to Robert F. Reed, R. R. 3, Rochester. Both are students at Indiana University School of Medicine.

Mr. Gunnoe's scholarship will amount to $2,000, as he is a freshman in medical school. Mr. Reed is a junior medical school student, and his scholarship will total $1,000.

Mr. Gunnoe, a native of Clinton, took his premedic training at Indiana University. Mr. Reed was a student at Manchester College for three years prior to entering medical school.

Upon completion of their internships, recipients of the scholarships are expected to practice medicine for a given period in some Indiana community in need of a doctor. The purpose of the scholarships is two-fold: to help worthy young men through medical school, and at the same time help rural communities solve their medical service problems.

AMERICAN COLLEGE OF PHYSICIANS MIDWEST REGIONAL MEETING

The Midwest Regional Meeting of the American College of Physicians will be held on the campus of the University of Wisconsin in Madison, Wisconsin, Saturday, November 18, 1950. Registration will begin at 8:00 A.M. and the scientific meetings will be followed by a social hour and dinner to be held at the Loraine Hotel in Madison, beginning at 5:30 P.M. The day will be filled by the presentation of scientific papers. Dr. J. O. Ritchey, Governor of the College for Indiana, will preside at one of the afternoon sessions.

Entertainment has been planned for the ladies, including a tea on Saturday afternoon at which Mrs. Oscar Rennebohm, wife of the Governor of Wisconsin, will be hostess. Tea will be served in the Governor's Mansion on the shores of Lake Mendota.

This meeting is open to all physicians whether or not they are members of the American College of Physicians. All physicians and their wives are cordially invited to be present and to participate.

Reservations for luncheon and dinner should be made immediately through Dr. H. M. Coon, 1300 University Avenue, Madison 6, Wisconsin.

FELLOWSHIP GRANTS

Recent public health service fellowship grants included one for Donald H. Simonson, at Indiana University, Bloomington, in the amount of $2,000, for the study of muscular excitation and the factors which influence it. These fellowships were awarded on the recommendation of the fellowships boards of the six National Institutes of Health (Heart, Cancer, Mental Health, Experimental Biology and Medicine, Microbiology and Dental), with the approval of Dr. Leonard A. Scheele.

UNIVERSITY OF MICHIGAN POSTGRADUATE COURSES

The University of Michigan has invited physicians of Indiana to attend their postgraduate courses, which will be held at the University Hospital, Ann Arbor, Michigan. The courses are as follows:

CLINICAL INTERNAL MEDICINE. Thursdays. October 5 to December 21, 1950; January 10 to April 19, 1951. 1:30 to 5:00 P.M.

CLINICAL EXERCISES FOR PRACTITIONERS. Wednesdays, October 18 to December 20, 1950. 10:00 A.M. to 5:00 P.M.

SPECIAL PATHOLOGY OF NEOPLASMS. Twice a week. Hours and days to be arranged. September 26 to November 17, 1950.

DIAGNOSTIC METHODS. CLINICAL AND LABORATORY INTERPRETATION. November 7-10, inclusive. 9:00 A.M. to 5:00 P.M.

CANCER. January 16-19, 1951. 9:00 A.M. to 5.00 P.M.

For further information, write to: H. H. Cummings, M.D., Chairman, Department of Postgraduate Medicine, University Hospital, Ann Arbor, Michigan.

ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Columbus, Ohio, May 24, 25 and 26, 1951, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy in duplicate sent to the Corresponding Secretary, Dr. George C. Shivers, 100 East Saint Vrain Street, Colorado Springs, Colorado, not later than March 1, 1951. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

A.M.A. COMMITTEE REPORTS ON BRITISH HEALTH SERVICE

Conclusions of the five-man A.M.A. Committee to Study Medical Care in England make it clear that the tremendously expensive experiment carried out under the National Health Act has degraded the practice of medicine and failed to improve the health of the British people.

The Board of Trustees last spring appointed five physicians qualified in internal medicine, surgery, pediatrics, general practice and industrial health to spend not less than six weeks in England, Wales and Scotland to inquire into the workings of the National Health Act and its probable future effect.

The report of the committee, composed of Walter B. Martin of Norfolk, Virginia, member of the Board of Trustees, Grover C. Penberthy of Detroit, Heyworth N. Sanford of Chicago, Ulrich R. Bryner of Salt Lake City, and Carl M. Peterson of Chicago, secretary of the Council on Industrial Health, was made to the House of Delegates in San Francisco and appears in the August 19 issue of *The Journal of the American Medical Association.*

In the course of the study, the committee members interviewed officers of the British Medical Association, Ministry of Health, and Fellowship for Freedom in Medicine; staff members of medical schools and hospitals, and a large number of general practitioners and others concerned with carrying out provisions of the service.

In summary, their fine report yields these conclusions:

1. The total cost of the service has far outstripped all estimates, and there is no evidence that the peak has been passed.

2. Despite the great amount expended for medical care in England, there is no present evidence that it has in any significant way improved the health of the people, or added to their happiness. All general hospitals have long waiting lists, in some categories as long as six months to two years. Out-patient departments are bulging. Offices of general practitioners in industrial areas are overcrowded and their facilities are grossly inadequate. Funds available for medical care have been dissipated on services that are not essential and essential services have suffered.

3. The tendency of the present system is to degrade the general practitioner to the level of a clerk or a guidepost to the specialist.

4. The service has produced a greater inequality of distribution of doctors, in proportion to population, and has diluted the quality of medicine.

5. It has added nothing to preventive medicine, but has disrupted public health work and produced serious problems in tuberculosis control and preventive dentistry.

6. It has created an almost complete autocratic control of medicine through concentration of financial power in the central government and the authority given the Minister of Health to govern by directions having the weight of law.

7. Abuses of the service are evident everywhere and must lead to more regulations, tighter enforcement, further limitations on freedom and further deterioration of the quality of medicine.

Secretary's Letter, A.M.A.

Dr. John Eric Dalton, of Indianapolis, who was vice-chairman of the Section on Dermatology and Syphilology of the A.M.A. for 1950-1951, has been appointed chairman of the section. Dr. Dudley C. Smith, of Charlottesville, Virginia, who was chairman, died recently.

Dr. Richard H. Schmidt, who recently completed his residency in radiology at the Methodist Hospital in Indianapolis, has become associated with the hospital as assistant radiologist. He is a Diplomate of the American Board of Radiology. A graduate of the University of Minnesota, Doctor Schmidt interned at the Milwaukee County Hospital, following which he served in the Army for two years.

ARMY AUTHORIZES APPOINTMENT OF WOMEN DOCTORS AS RESERVE CORPS OFFICERS

Appointment and concurrent assignment to active duty as Reserve Officers of women physicians, dentists, and allied specialists, has been authorized, it was announced by the Department of the Army.

This marks the first time authorization has been given for women to be commissioned in the Medical, Dental, Veterinary, and Medical Service Corps Reserves. They will be brought on duty under regulations currently providing for the commissioning of male officers in these Corps. Some women did serve in the Army as physicians and technicians during World War II, but their commissions have expired.

As Reserve officers on active duty, these women will be given opportunities for clinical practice and advancement which are now available to male officers in comparable grades, Major General R. W. Bliss, Surgeon General of the Army, pointed out. Appointments will be in grades from first lieutenant to colonel, depending upon age, experience, and professional qualifications. The pay, allowances, dependency and retirement benefits which accrue to male officers will apply to the women medical reservists. Women physicians and dentists will also draw the $100 a month professional pay allowed above the base pay of their commissioned rank. They will be eligible for service in every type of military medical facility, with the exception of forward medical installations in combat zones.

General Bliss said his office had received numerous letters during the past year from women physicians desiring military service.

ARMY POLICY ON MEDICAL RESERVE OFFICERS

The Department of the Army has announced the recall of 1,582 reserve officers of the four male corps of the Army Medical Service, including 734 physicians, 343 dentists, 50 veterinarians and 455 Medical Service Corps officers. All of these officers will be recalled not later than October 1, with most coming on active duty in September.

Two major phases of the recall are expected to result in a minimum of dislocation to civilian health services and assurance of appropriate assignments to all those entering active duty. First, recall quotas assigned to each of the six Army areas in the United States have been based on professional population rather than the number of reserve officers in the area. Thus, the Army areas with the smallest proportion of physicians to the civilian population will have the smallest quotas, regardless of the relative reserve officer strength. Second, quotas for Army areas also specify grades and special skills required. Officers will be recalled in their present Reserve grades.

The Army will continue to make every effort to obtain volunteers for 21 months' service to fill requirements. Volunteers will be credited to the quota of the Army area in which they reside.

One major advantage accruing to volunteer physicians and dentists will be an additional $100 monthly professional pay. Under the legislation authorizing this additional pay, it may go only to volunteers.

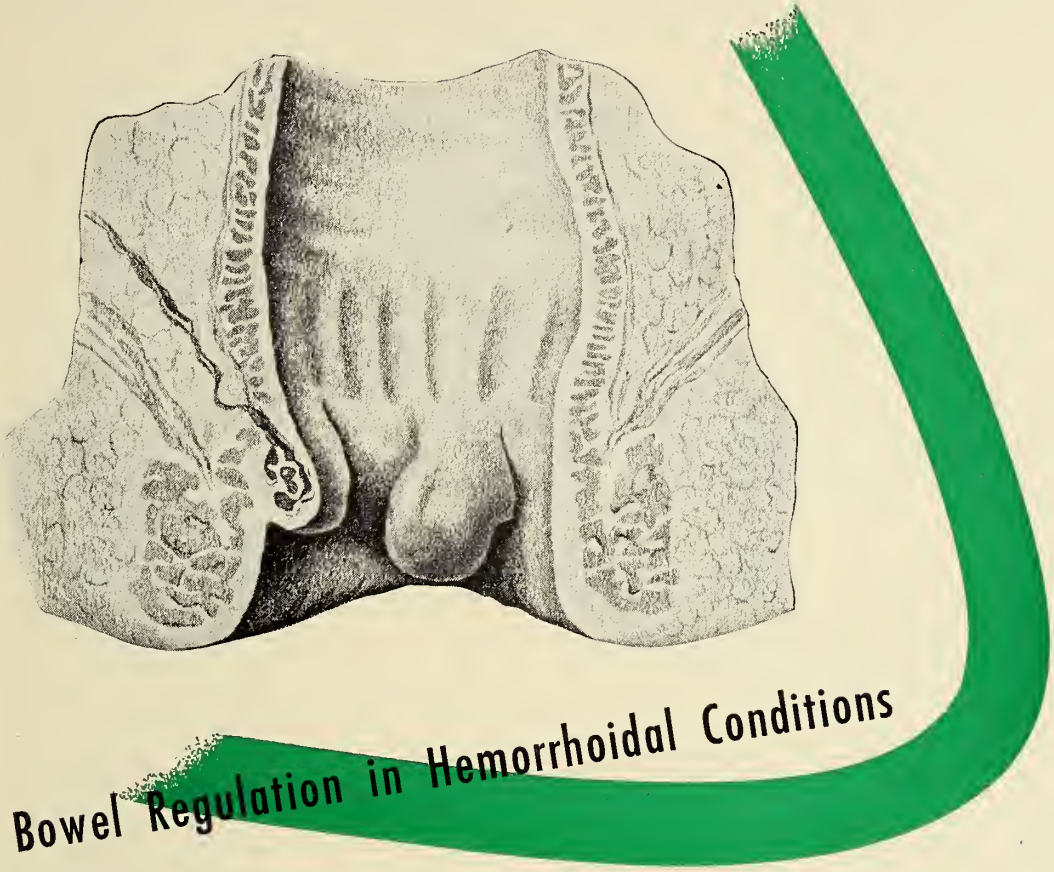
Priority for involuntary recalls to meet quotas will be given to Reserve officers with the least active duty service. Thus, Reserve officers with considerable wartime service will normally be among the last called. However, in many cases the operation of the priority system will depend on the number of Reserve officers available in a given specialty. Reserve officers who are members of Organized Reserve units which have not been alerted or scheduled for an early alert may be subject to individual call.

Delay has been authorized in calling up five categories of Army Medical Service Reserve officers. These are:

1. Reserve medical officers, who have not completed one year's internship.
2. Senior medical and dental residents until completion of their current year's training.
3. Reserve officers enrolled in full-time postgraduate courses in medicine, dentistry or other closely allied sciences at a recognized institution of higher learning until completion of their current academic year.
4. Reserve officers engaged in essential teaching, research and allied endeavors.
5. Reserve officers whose recall would unduly jeopardize the health of a community.

Authorization for delays under any of these categories will be granted by military district commanders.

Army commanders have been directed to enlist the assistance of state and local medical, dental and veterinary societies as well as that of senior Reserve medical, dental and veterinary officers.



When there is a tendency toward hemorrhoids, when hemorrhoids are present or after hemorrhoidectomy—when avoidance of straining is desired—Metamucil's smooth, demulcent action conforms to accepted bowel management.

Metamucil softens the fecal content, stimulates peristalsis by supplying plastic, bland bulk and encourages easy, gentle, regular evacuation without irritation or straining.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

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Dr. John A. Shively, who has been resident physician at the Caylor-Nickel Clinic in Bluffton, has become associated with the South Bend Medical Foundation, an affiliate of the Memorial Hospital at South Bend.

A 1937 graduate of the University of Iowa School of Medicine, **Dr. John P. Turner** has opened an office for the general practice of medicine in Goshen. He interned at Mary's Help Hospital in San Francisco, and served with the active corps of the U. S. Public Health Service. For the past two years Doctor Turner has been assistant chief of medicine at the U. S. Marine Hospital in Chicago.

Dr. E. M. Truman of Indianapolis has opened an office in Rushville, following his internship at St. Vincent's Hospital, in Indianapolis. He graduated from Indiana University School of Medicine in 1949.

Dr. John H. Alward, of South Bend, has opened an office in Kokomo, for the practice of surgery. A 1941 graduate of the Indiana University School of Medicine, he interned at Indianapolis General Hospital, and took special training in surgery at the Mayo Clinic in Rochester, the City Hospital of Akron, Ohio, and at the University of Pennsylvania Graduate School of Medicine. Doctor Alward spent three years with the Army Air Corps at regional hospitals at St. Louis, Sioux Falls, South Dakota, and at Salina, Kansas.

Dr. H. Haskell Ziperman, who served for approximately four years during World War II, has returned to active duty with the Army. A 1941 graduate of Indiana University, Doctor Ziperman has been a surgical resident at the Indiana University Medical Center before returning to the service.

Dr. Elmer R. Billings, formerly of Washington, has opened offices in association with **Dr. Hugh A. Miller** in Elkhart. Doctor Billings graduated from Indiana University School of Medicine in 1944, and following two years in the Army, he served a three-year residency in medicine at Indianapolis General Hospital.

A native of Gary, **Dr. Alexander F. Craig** has opened an office for the practice of anesthesiology in New Castle. He is a veteran of World War II, in which he served as battalion surgeon in England, France and Germany. Following his release from service, Doctor Craig went to Knightstown, where he practiced for two years, before taking two years of postgraduate work in anesthesiology at Indiana University Medical Center.

Dr. Thomas R. Havens recently opened an office in Jeffersonville for the general practice of medicine. He is a graduate of the University of Louisville School of Medicine, and interned at St. Anthony's Hospital in Louisville.

Dr. M. E. Johnson of Decatur has begun the practice of medicine in association with **Dr. C. W. Atkinson** in Boswell. Doctor Johnson is a graduate of Indiana University School of Medicine, and completed his internship at the Kansas City General Hospital.

Dr. F. N. Sellers has opened an office at 1404 Lincoln Way East, in South Bend, for the general practice of medicine. A veteran of World War II, he formerly practiced in Mount Morris, Illinois. Following his graduation from Northwestern University School of Medicine in 1945, he took postgraduate work at Wesley Memorial Hospital in Chicago.

Dr. William T. Sallee recently opened an office for the general practice of medicine in Greensburg. He is a graduate of the Jefferson Medical College of Philadelphia, and interned at St. Vincent's Hospital, in Indianapolis.

Dr. Ben L. Leming recently opened offices at 1135 Lincoln Bank Building in Ft. Wayne for the practice of general surgery. A 1942 graduate of Indiana University School of Medicine, he interned at the City Hospital in Springfield, Ohio, before entering the service. He spent three years in the Army Air Force surgical services. Doctor Leming then spent three years in surgical residency at Veterans Hospital in Batavia, New York, and for the past year has been studying the surgical treatment of malignant diseases at the Roswell Park Memorial Institute in Buffalo.

A native of Logansport, **Dr. Charles Martin** has opened an office at 224 South Mill Street in South Bend for the practice of internal medicine. He graduated from Indiana University School of Medicine in 1942 and interned at Indianapolis General Hospital. Following three years of service with the U. S. Army, he interned in the Ancker Hospital at St. Paul, Minnesota, and at the two veterans hospitals in Indianapolis.

Dr. Glynn Rivers, of Muncie, a lieutenant in the U. S. Naval Reserve, was recalled to active duty on August 25, when he reported to the Naval Hospital at Oakland, California. A 1939 graduate of Indiana University School of Medicine, Doctor Rivers served in the Navy from September, 1943, to June, 1946, including twenty-three months in New Guinea and the Philippines.

A urinary tract infection

Resistant to "*. . . all available antibiotics and chemotherapeutic agents.*"[1]

TREATED WITH TERRAMYCIN

M.F., male, age 48

History: Pyelonephritis, 1½ years' duration following ureterocutaneous implants (mixed infection: P. vulgaris, E. coli, Staph. albus, enterococci); previous therapy with all available antibiotics and chemotherapeutic agents without response.

Therapy: Terramycin, 2 Gm. daily for 5 days; orally in divided doses q. 6 h.

Result: Urine culture negative except for P. vulgaris by 2nd day of treatment. Response described as "good".

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Terramycin

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New Council-accepted broad-spectrum antibiotic orally effective — well tolerated

1. Terramycin may be highly effective even when other antibiotics fail.[1]
2. Terramycin may be well tolerated even when other antibiotics are not.[2]

suggested for: *acute pneumococcal infections, including lobar pneumonia, bacteremia; acute streptococcal infections, including erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; bacillary infections, including anthrax; urinary tract infections due to E. coli, A. aerogenes, Staphylococcus albus or aureus, and other Terramycin-sensitive organisms; acute brucellosis (abortus, melitensis, suis); hemophilus infections; acute gonococcal infections; lymphogranuloma venereum; granuloma inguinale; primary atypical pneumonia; typhus (murine, epidemic, scrub); rickettsialpox.*

Dosage: 2 to 3 Gm. daily by mouth in divided doses q. 6 h. is suggested for acute infections.

Supplied: 250 mg. capsules, bottles of 16 and 100; 100 mg. capsules, bottles of 25; 50 mg. capsules, bottles of 25.

1. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R.B., and Cornely, P. B.: J. A. M. A. 143:1 (May 6) 1950.

2. Herrell, W. E.; Heilman, F. E.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950

Pfizer *Antibiotic Division*

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Dr. Joseph C. Manning, Jr., is associated with Dr. D. S. Megenhardt, at 1015 Hume Mansur Building, in Indianapolis, in the practice of surgery.

A graduate of the University of Louisville School of Medicine, **Dr. Harry E. Stout** has opened an office in Frankfort for the practice of medicine. He interned at St. Louis General Hospital, and practiced for four years in Colfax. In July of this year he took two months postgraduate work at Harvard School of Medicine. Doctor Stout served for two and a half years in World War II.

Dr. Daniel J. Rothenberger, who recently completed his internship at St. Vincent's Hospital in Indianapolis, has been assigned to the 509th Medical Group at Walker Air Force Base in Roswell, New Mexico.

A 1949 graduate of Indiana University School of Medicine, **Dr. Bernard J. Dolezal** has opened an office for general practice in South Bend, after completing his internship at St. Vincent's Hospital in Indianapolis.

Dr. Mark H. Huckeriede has opened an office for general practice in Circleville, Ohio. A 1949 graduate of Indiana University School of Medicine, Doctor Huckeriede recently completed his internship at the Methodist Hospital in Indianapolis.

Dr. Charles F. Martin, who has been on the staff at Billings VA Hospital at Ft. Benjamin Harrison, has opened an office in Mishawaka for the practice of internal medicine.

Dr. Rodney B. Fruth has opened an office for the practice of medicine and surgery in Connersville. He is a graduate of the Albany College of Medicine, in Albany, New York, and interned at Indianapolis General Hospital.

Dr. Justin C. Schubert has established an office for the practice of medicine at Crown Point. A 1948 graduate of Indiana University School of Medicine, Doctor Schubert interned at the Santa Monica, California, hospital, and then spent a year's service in the Navy.

Dr. Elmer E. Peters has opened an office for the practice of medicine at 830 Main Street, in Brookville. He is a 1949 graduate of Indiana University School of Medicine, and interned at St. Vincent's Hospital in Indianapolis. Doctor Peters has taken over the office of Dr. H. R. Hoeger, who has gone to Tulane University to take special work in otolaryngology.

Dr. Carl J. Brunoehler, a 1948 graduate of Indiana University School of Medicine, is associated with Drs. Moore and Hurley in Muncie. Doctor Brunoehler recently completed a second year internship in surgery at Indianapolis General Hospital.

Deaths

James H. Smiley, M.D., of Indianapolis, died on August 25 at the age of seventy-one. He was a graduate of the State College of Physicians and Surgeons, in Indianapolis, in 1907, and had practiced in Indianapolis since that time. Doctor Smiley was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

Clifford O. Richey, M.D., of Evansville, died on September 8, at the age of fifty-one. He was a 1922 graduate of the Indiana University School of Medicine and practiced in Indianapolis before going to Evansville in 1935. Doctor Richey was a member of the Vanderburgh County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Albert W. Collins, MD., of Anderson, died on August 17 after a long illness. He was seventy-seven years of age. He was an Honorary member of the Madison County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association. Doctor Collins graduated from the Medical College of Indiana, in Indianapolis, in 1896, and had practiced in Anderson for forty-seven years, before he retired in 1945.

Charles H. Ruch, M.D., of Momence, Illinois, died on August 2, at the age of fifty-four. He had practiced in Brownstown from 1928 to 1935, before going to Momence. He graduated from Indiana University School of Medicine in 1926.

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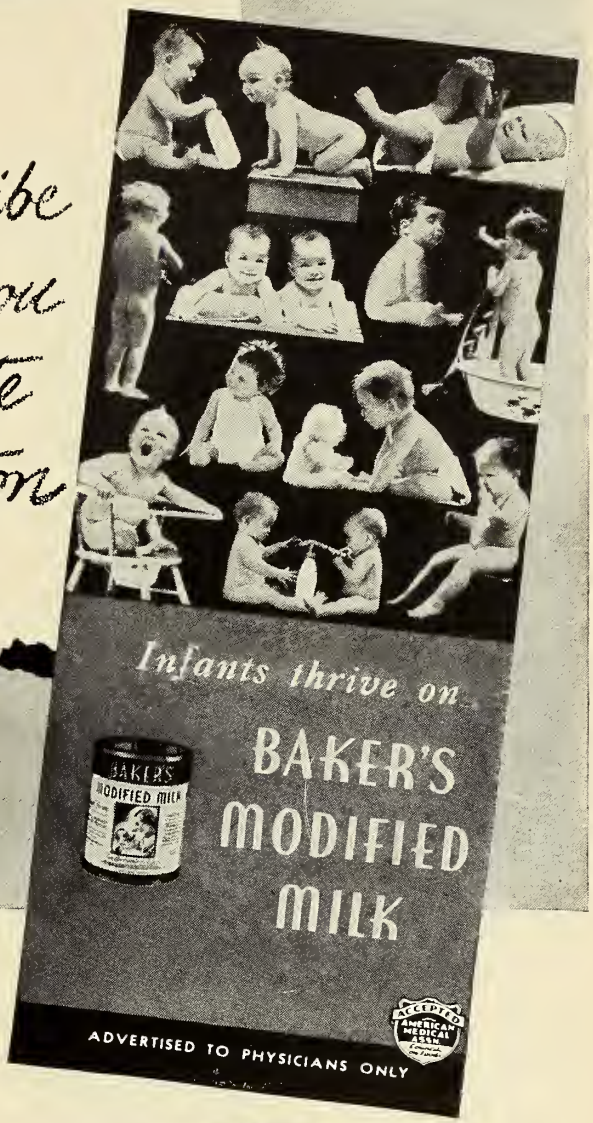

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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

PHYSICIAN'S HANDBOOK. By Marcus A. Krupp, M.D., assistant clinical professor of medicine, Stanford University School of Medicine; Norman J. Sweet, assistant professor of medicine, University of California School of Medicine; Ernest Jawetz, M.D., associate professor of bacteriology, University of California School of Medicine; and Charles D. Armstrong, M.D., clinical instructor in medicine, Stanford University School of Medicine, Sixth Edition. 382 pages. Price $2.50. University Medical Publishers, P. O. Box 761, Palo Alto, California, 1950.

ATOMIC ATTACK—A Manual for Survival. By John L. Balderston, Jr., and Gordon W. Hewes. Published under the auspices of Council On Atomic Implications, Inc., Los Angeles. 64 pages. Price $1.00. Murray & Gee, Inc., 3630 Eastham Drive, Culver City, California, 1950.

NURSING IN PREVENTION AND CONTROL OF TUBERCULOSIS. By H. W. Hetherington, M.D., chief of clinic of the Henry Phipps Institute of the University of Pennsylvania; and Fannie W. Eshleman, R.N., supervisor of Public Health Nursing of the Henry Phipps Institute of the University of Pennsylvania. Third edition. 361 pages, with 12 illustrations. Price $4.50. G. P. Putnam's Sons, 2 West 45th Street, New York City, 1950.

THE ANTIHISTAMINES. Their Clinical Application. By Samuel M. Feinberg, M.D., associate professor of medicine, chief of Division of Allergy, and director of Allergy Research Laboratory; Saul Malkiel, M.D., assistant professor of medicine, director of research, Allergy Research Laboratory; and Alan R. Feinberg, M.D., clinical assistant in medicine, attending physician in Allergy Clinic, all of Northwestern University Medical School. 291 pages. Price $4.00. The Year Book Publishers, Inc., 200 East Illinois Street, Chicago, 1950.

THE TRUTH ABOUT YOUR EYES. By Derrick Vail, M.D., head of the Department of Ophthalmology at Northwestern University Medical School, editor-in-chief of the American Journal of Ophthalmology. 180 pages, with 6 illustrations. Price $2.50. Farrar, Straus and Company, Inc., 53 East 34th Street, New York City, 1950.

PRINCIPLES OF PUBLIC HEALTH ADMINISTRATION. By John J. Hanlon, M.D., associate professor of Public Health Practice, School of Public Health, University of Michigan. 506 pages, with 48 illustrations. Price $6.00. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri, 1950.

CEREBRAL PALSY. By John F. Pohl, M.D., orthopedic surgeon, Michael Dowling School for Crippled Children, Minneapolis. 224 pages with 131 illustrations. Price $5.00. Bruce Publishing Company, 2642 University Ave., St. Paul 4, Minnesota, 1950.

THE MANAGEMENT OF OBSTETRIC DIFFICULTIES. By Paul Titus, M.D., obstetrician and gynecologist to the St. Margaret Memorial Hospital, Pittsburgh. Fourth edition. 1046 pages, with 446 illustrations and 9 color plates. Price $14.00. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri. 1950.

DOCTOR COME QUICKLY. By Frank J. Clancy, M.D., Seattle, Washington. 248 pages. Price $2.95. Superior Publishing Company, Box 2190, Seattle 11, Washington.

BOOK REVIEW

THE MASK OF SANITY. By Hervey Cleckley, M.D., professor of psychiatry and neurology, University of Georgia School of Medicine, Augusta, Georgia. Second Edition. 569 pages. Price, $6.50. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis, Missouri, 1950.

The author has lucidly and interestingly presented a comprehensive study of people generally known as psychopaths. Doctor Cleckley, a prominent authority on the subject, has probably devoted more study to this particular mental disorder than any other observer. The study is timely in that it deals with one of our most serious and difficult social and medical problems, the dangerous individual who is not legally insane and who has not yet been convicted of a crime. The author emphatically points out that at present the law provides no practical means by which the community can protect itself from these people.

In order to give the reader a clear understanding of this particular mental aberration, Doctor Cleckley includes a section of material which consists of case histories of individuals affected with disorder in full clinical manifestation. This material is well organized and very readable, even for one who is not trained in psychiatry. The case histories are not at all dull, but read like stories, for we have all known such people.

Fifteen characteristics of the psychopath are briefly discussed in fifteen chapters of the book. Here the author attempts to show us what the psychopath is in terms of his actions and how he thinks. The reader is given a pattern to distinguish these individuals from patients suffering from other forms of mental disease.

One section of the book is devoted to interpretation of the disorder and the final section is devoted to therapy. The author avers that all of these people should be under competent and constant medical supervision, and that there are many patients with psychopathic disorders more in need of medical supervision than many of those now in institutions for psychoses and mental defectiveness. The 226 references, which conclude the book, greatly enhance its value.

This book presents such important material in such an interesting fashion, that it is particularly valuable to lawyers, teachers and social workers, as well as practitioners in all branches of medicine.

D. A. B.

BOOKS REVIEWED

HISTOLOGY. By Arthur Worth Ham, M.B., professor of Anatomy, in charge of Histology, in the Faculties of Medicine and Dentistry, University of Toronto, Canada. 766 pages, with 445 figures, including 4 color plates. Price $10.00. J. B. Lippincott Company, East Washington Square, Philadelphia, Pa., 1950.

In his preface, the author states: "I suppose that my desire to write a book and, in particular, one that would be easy for students to understand, was born while I was a medical student as a result of having to use so many books that were difficult to understand." It is the reviewer's opinion that this aim has been accomplished. For example, the diction used is simple, direct and clear, although there is no lack of technical terminology. The illustrations are of the clear, large type usually seen in high class research publications, but rarely in textbooks. Furthermore, the labels are unmistakable and sufficiently numerous, so that between them and the legend the student should not go astray.

As to the organization of subject matter, this is presented in four main parts: (1) What Histology Is and How It Is Studied; (2) Cells, Intercellular Substances and Fluids; (3) the Four Primary Tissues and Their Subdivisions; and (4) the Histology of the Systems.

This schema turns what used to be presented as a kaleidoscope of tissues and cells into an ordered arrangement, which is intelligible and easily assimilated because of the functional approach. Indeed, this author presents histology as microscopic anatomy **plus** enough microscopic physiology to inject life "as she is lived" into a usually dry subject.

The book is distinctly modern in concept, offering a full histologic basis for the student to proceed in studies on degenerative diseases of the heart and arteries (chapter on intercellular substances, their role in structural support and nutrition of cells, hyaluronidase), cancer (growth and differentiation, nucleoproteins), psychosomatic medicine (autonomic innervation of smooth muscle and glands), arthritis (chapter on articulations), and hormonal balance (endocrine glands and reproductive system), to mention several.

In many portions the text is flavored by the inclusion of much original work, such as the chapter on bone (a clear presentation of a very dense subject), the chapter on skin (which includes original work on capillary beds affected by burns, repair of skin and vascularization of skin grafts), and the account of the development of the lung and of the nature of respiratory tissue. In fact, the general tone of the entire book, plus the definite portions of original research scattered through it, should stimulate the student's interest in scientific research and in methods of research. Mr. Ham has indeed made a notable contribution to medical pedagogy.

A. W. C.

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BOOKS REVIEWED

THE PRACTICE OF MEDICINE. By Jonathan Campbell Meakins, M.D., formerly professor of medicine and director of the Department of Medicine, McGill University. Fifth edition. 1,558 pages, with 518 illustrations, including 50 in color. Price, $13.50. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis, Mo., 1950.

Like the previous editions of this well-known work, this book is truly a masterpiece. As in the previous editions, the material is well-organized and written with excellent word selection, and it is comprehensive in its scope. The photomicrographs as well as the gross photography are well done.

As the author points out, the advances in medical science in recent years necessitate an almost complete revision of every chapter. Through the past few decades, medical thought has turned from the school of pathological anatomy led by Virchow to a greater consideration of pathologic or abnormal physiology. Also at the present, man's reaction to his environment receives serious consideration from the physician.

Although this book is written primarily for the student and general practitioner of medicine, the ample references at the end of each chapter cover a great portion of the world's recent literature in every branch of medicine.

In the present edition a section on psychosomatic medicine by Dr. Frederick R. Hanson has replaced the section of psychiatry which appeared in the previous editions. This chapter consists of 41 pages, and in some detail takes up the psychophysiological considerations involved in functional disorders. At some length the psychological factors related to disorders of various body systems and specific organs are discussed. The consideration of psychotherapy is presented in a manner which is readily understandable to the average physician who is not especially familiar with psychoanalytic or psychiatric techniques.

An added feature of this edition is the chapter on chemotherapy and antibiotics. The indications, administration and dosage of the various agents are described in detail. The numerous toxic effects of the various sulfonamides are described and listed in table form. One interesting feature of this chapter is the table showing the various organisms that are particularly affected by the administration of the antibiotics. The prophylactic as well as the curative use of these agents is presented with a conservative attitude. The author wisely warns that these agents are to be used for specific infections and not indiscriminately.

This book is one of the best medical texts that has ever been published and can be highly recommended to students and physicians.

D. A. B.

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ANURIA RESULTING FROM SULFONAMIDE THERAPY

F. B. ADNEY, M.D. AND J. I. WALLER, M.D.*

INDIANAPOLIS

SINCE Hawking observed crystalluria in experimental animals receiving sulfanilamide in 1937, the literature has contained numerous reports of the renal complications of sulfonamide therapy.[1] The following year the clinical use of sulfanilamide demonstrated the tendency to precipitation and the possibility of stone formation.[2] In 1939 Antopol and Robinson reported the production of obstructive uroliths in rats, rabbits, and monkeys with sulfapyridine.[3] Tsao and others, in the same year, reported a fatal case of anuria due to ureteral obstruction by sulfapyridine concretions.[4] A similar case was reported a few months later in which the ureteral obstruction was relieved by ureteral catheters.[5] Although physicians have been familiar with these renal complications of sulfonamide therapy, they still occur and, we feel, justify this paper.

A case of anuria resulting from sulfadiazine therapy successfully treated at Indianapolis General Hospital has caused us to search the records of this institution on this subject. Since the advent of the sulfonamides there have been fifteen cases, not including agranulocytosis, of marked reaction to the drug in patients treated at this hospital. These fifteen cases presented twenty-one manifestations of reaction to the drug. There were six each of hematuria and skin rash, five of febrile reaction, two of crystalluria, and one each of oliguria and anuria. We were surprised to find only the one case of anuria. The type of sulfonamide used was sulfadiazine in six cases, sulfathiazole in six, a combination of sulfathiazole and sulfamerazine in one, and unknown in two cases. Of the fifteen patients, ten had received sodium bicarbonate with the sulfonamide and five received no alkali. This group of cases is too small to attempt any correlation between the type of drug administered and the reaction manifested. There were no deaths in this group resulting from sulfonamide toxicity.

Sulfonamide therapy may cause renal complications manifested by crystalluria, hematuria, albuminuria, oliguria or anuria, azotemia, renal or abdominal pain and tenderness, and enlargement of the kidney.[6] This paper will deal primarily with anuria as a complication of therapy.

According to Hamer and Mertz, the commonly accepted classification (Eisendrath) of anuria divides the causes into pre-renal, renal, and post-renal; and the types into secretory, transitional, and obstructive.[7] Anuria as a complication of sulfonamide therapy may be of renal or post-renal cause and of all types. The diagnosis of anuria as

From the Department of Urology, Indianapolis General Hospital

* Dr. John I. Waller is now head of the department of Urology, at The Hertzler Clinic, in Halstead, Kansas.

the result of sulfonamide therapy depends upon ruling out other possible causes of anuria as well as the presence of sulfa crystals in the scanty output of urine.

PATHOLOGY

The pathologic changes produced in the kidney as a complication of sulfonamide therapy are described by Abeshouse and Tonkin as: (1) mechanical by the deposition of crystals in the tubules, pelvis, or ureter and, (2) chemical with the development of an acute toxic and degenerative nephritis.[6] Ormond and Roth also describe areas of focal necrosis in the renal parenchyma.[8] Hellwig and Reed feel that anuria is the result of parenchymal damage rather than mechanical blocking; however, in their case post-mortem examination did reveal the renal pelves and ureters to be filled with clot containing crystals as well as severe tubular degeneration.[9] A case of anuria resulting from allergic edema of ureters after the administration of a small dosage of sulfadiazine has been reported by Finegold.[10] Carroll, Kappel, and Lewis believed that renal damage was primarily mechanical with the insoluble acetylated form of the drug blocking the renal capillaries, tubules, and pelvis.[11] We believe that each of these mechanisms applies to certain cases and that with the exception of the allergic type of reaction, the tendency of the drug to crystallize is of primary importance.

FACTORS OF CRYSTALLIZATION

The crystallization of the sulfonamides in the renal parenchyma and collecting system is influenced by several factors. The concentration of the drug in the urine is dependent upon the dosage, renal function, and urinary output. The degree of acetylation of the drug is of importance since the acetyl form is more insoluble as well as being therapeutically inactive. Acetylation varies with the type of sulfonamide as well as with the individual patient; in the case of sulfanilamide, it varies from 30 per cent to 70 per cent; with sulfathiazole, it is not over 30 per cent and is usually much less; while in the case of sulfapyridine, it has been found to vary widely. It has been pointed out that the relative nontoxicity of sulfadiazine may be due to the fact that the solubility of its acetyl form is much higher than that of the acetyl forms of sulfapyridine and sulfathiazole.[13] The presence of an inflammatory or obstructive lesion in the upper urinary tract is believed to promote crystallization.[6, 14]

The hydrogen ion concentration of the urine is another factor in crystallization of the sulfonamides. Jensen and Fox found the solubility is minimal at pH 5.6 to 6.6, doubled or tripled at pH 7.5, and increased tenfold at pH 8.0.[15] Solubility of the drug is also increased by an elevation in temperature; therefore crystallization is more likely to occur when the patient becomes afebrile.[6, 14] Even the race of the patient may be a factor, for one article has reported that anuria and sulfonamide concretions occur more frequently in the Oriental than in the white race.[14] In some cases, crystallization seems to be the result of an idiosyncrasy to the drug rather than physical and chemical factors.[7] The crystals found in the kidneys of a patient who has died in anuria following sulfonamide therapy are usually assumed to be the crystals of that drug. But there have been two cases reported in which the crystals were found to be uric acid and urates.[7, 16] On the other hand, sulfa crystals occluding renal tubules may not be found in the routine preparation of microscopic sections which dissolves these crystals.[17]

Prevention of sulfonamide crystallization consists of recognition of and regulation where possible of the above mentioned factors. Therapy with mixtures of sulfonamides has been advocated as a means of increasing solubility. However, this tends to give a false sense of security since doubling the solubility of sulfonamide compounds by using equal parts of two drugs instead of the same total dose of one drug "does not necessarily reduce crystal formation to one-half."[18] Nevertheless, only partial increase in solubility by the use of mixtures of sulfonamides is advantageous and when these mixtures are combined with regulation of concentration and pH an even greater solubility results.

TREATMENT

Treatment of anuria as a result of sulfonamide administration is initiated by stopping further administration of the drug, administration of sodium bicarbonate, and maintenance of adequate fluid balance. Cystoscopy and ureteral catheterization should promptly be performed to diagnose and treat ureteral and pelvic obstruction by concretions. In many cases, including our own, ureteral catheterization has promptly established urinary excretion. When crystalluria is found the renal pelves may be lavaged with warm sodium bicarbonate solution to promote dissolution of concretions. Renal diathermy has been used as an additional means of promoting solubility.[8, 19] Urea may be used as a solvent for sulfonamide crystals. Five grams of urea in five ounces of lemonade every four hours for six doses is recommended.[7] In the event that no mechanical block is found some authors advocate renal decapsulation. This procedure may improve renal blood flow by mechanically releasing tension on a swollen kidney or by the interruption of sympathetic nerve connections between the capsule and cortex.[20] Heslin advocates nephrostomy and decapsulation in those cases not responding to more conservative therapy.[21] Recent work has shown that the old motto of forcing fluids in cases of anuria has resulted in drowning. For the scope of this paper, suffice it to say that body physiology should be aided rather than antagonized.

CASE REPORT

An 83-year-old white woman was admitted to the Medical Service of Indianapolis General Hospital on 4-8-49. Her illness had begun eight weeks prior to admission with a sore throat which subsided in one week, but was followed by a productive cough. She had had no orthopnea, dyspnea, chest pain, or hemoptysis. Two weeks before admission she consulted her physician and was given sulfadiazine—2 grams initially and 5 grams daily in divided doses for 7 to 12 days. Soda bicarbonate was not administered. After one week of therapy the patient developed oliguria. Three liters of intravenous fluids were administered at home but no improvement noted in output. Catheterization the day before and the day of admission produced no urine. In addition to a productive cough she had had intermittent fever and night sweats for eight weeks, and no bowel movement the last week until the night before admission, when an enema produced poor results. Her past history revealed an episode of moderate cardiac decompensation four years ago.

Positive physical findings were obesity, slight pallor, and mild dehydration. Cardiac enlargement was noted with moist rales in the lung bases posteriorly. Blood pressure was 152/46; temperature 99.4°; pulse 100; respiration 20. Abdomen was distended and tympanitic with decreased bowel sounds and lower abdominal tenderness on deep palpation.

Laboratory: Hg.—12.0, R.B.C.—4.1, W.B.C.—12,400, N.P.N.—57, CO_2—42, Chlorides—590.

Consultation with the Genito-Urinary Service was requested by Dr. Robert Marvel.

On 4-9-49 cystoscopic examination under local anesthesia revealed a snow storm of crystals in the bladder medium. Both ureteral orifices contained crystals. Repeated attempts to catheterize the ureters with numbers 6, 5, and 4 catheters, with and without stylet, and Wishard tipped catheters were unsuccessful.

On 4-10-49, the N.P.N. had risen to 84. Cystoscopy was repeated under spinal anesthesia. The ureteral orifices were still plugged with crystals. Ureteral catheters could not be passed with the cystoscope, but with a panendoscope, No. 6 catheters were passed to both pelves. As the catheters passed up the ureters, old blood and crystals were pushed out of the orifices. The right catheter drained brown urine rapidly dropwise; the left released a stream of urine of the same appearance and under considerable pressure. The pelves were lavaged with soda bicarbonate solution. The urine was brown, cloudy, and acid. There were 10 to 20 W.B.C.'s, many R.B.C.'s, a few casts, a few sulfa crystals, and abundant amorphous debris per high power field. The right side had a trace of albumin and negative sugar while the left had 2 plus albumin and 1 plus sugar. Urine culture was reported as E. coli and A. aerogenes bilaterally.

Sixteen hours after catheterization, 425 cc. of urine had passed from the left ureteral catheter, 350 cc. from the right, and also 360 cc. from the urethral catheter. The N.P.N. was 56. By the fourth day the 24-hour output was over four liters and the N.P.N. 45. The ureteral catheters were removed on the fifth day. Streptomycin was prescribed for five days. Urinary output was maintained at a satisfactory level and urinalysis became normal. The patient was released, symptom-free, on the seventeenth hospital day.

SUMMARY

Anuria resulting from sulfonamide therapy may occur from an idiosyncrasy or sensitivity reaction of the patient to the drug or from crystallization and concretion formation of the free and acetylated forms. The former type of reaction may be anticipated if the patient has had previous therapy with sulfonamides or sensitivity to other drugs and may occur after the chemically negligible dose has been given. The latter type of reaction is generally the result of physical and chemical factors of solubility, although here, too, sensitivity may play a part. Treatment is directed toward maintaining body physiology and promoting solubility of sulfonamides in the urine. A case is reported which was cured by ureteral catheterization.

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SEBORRHEIC DERMATITIS

Don E. Kelly, M.D., and Theodore D. Arlook, M.D.*

INDIANAPOLIS ELKHART

SEBORRHEIC DERMATITIS[1] is a common dermatosis and is manifested by patches of yellowish, greasy scales. It most commonly affects the scalp but often is present in the so-called seborrheic areas—the forehead, eyebrows, nasolabial folds, chin, presternal and interscapular areas, and may even involve the sacral and intertriginous areas.

Older writers considered the clinical manifestations of seborrhea and seborrheic dermatitis as being only somewhat interrelated. At first they separated the various clinical entities of seborrheal manifestations under various names and titles usually descriptive of the dominant cutaneous manifestations, i.e. seborrhea, eczema seborrheicum (Unna), ichthyosis sebacea, seborrhea corporis (Duhring), seborrhea figuree' (Brocq), hyperidrosis oleosa (Brocq), lichen circumscriptus (Willan), lichen annulatus et serpiginosus (Wilson),[2] et cetera.

This confusing classification of the various seborrheic dermatidides was considerably clarified and the basic similarity between seborrhea and seborrheic dermatitis was pointed out in the classic works of Unna and Sabouraud.[3, 4]

Seborrheic dermatitis may be mild or disabling, localized or generalized. It may be indolent for months or years and then acutely flare up. The disease may keep a patient in the hospital for months.

The term seborrhea means an excessive output of sebum which is a product of the sebaceous glands. Sebum is a true secretion and contains fatty acids combined with the higher alcohols including cholesterol.

ETIOLOGY

It appears that the fertile soil of the seborrheic enhances the growth of:

1. Pityrosporum ovale (bottle bacillus of Sabouraud or flask-shaped bacillus of Unna).

2. Microbacillus of Unna and Sabouraud (Bacillus acne of Gilchrist).

3. Staphylococcus epidermis albus of Welsh (the grey bacillus).

Barber[5] also speaks of the triad of organisms gaining a foothold at puberty due to a greater activity of the sebaceous glands, dietary errors, and a lack of exercise. Ingram[6] stated constitutional background, gastro-intestinal dysfunction and malnutrition as a factor in seborrheic eczema, and based his remarks on theory of diathesis.

Dowling[7] stated that seborrheic dermatitis is due to a primary infection by yeast-like organisms (bottle and flask-shaped bacilli), usually saprophytes, but which are capable of becoming pathogenic. Keil and Engman[8] share Dowling's viewpoint.

Agnes Savill[9] describes the bottle bacillus as being present before puberty in the pityriasis sicca stage (dry scaling). She speaks of the polymorphous coccus and staphylococcus albus being present in the pityriasis steatoides stage (sticky and thick scaling), between the ages of fifteen to seventeen years. The seborrhea oleosa stage (very oily scales), and the one in which the microbacillus is found, is present between the seven-

* Former Resident in Department of Dermatology and Syphilology, Indianapolis General Hospital.

teenth to twentieth year. The microbacillus is likewise found in comedones, and loss of hair often occurs in this stage.

Jolliffe, Fein, and Rosenblum[10] feel that a vitamin B complex deficiency is an essential element in the etiology of seborrheic dermatitis, especially the riboflavin and pyridoxine components. James B. Hamilton's[11] investigations on seborrhea and acne vulgaris with relation to hormones have been noteworthy. Eunuchs and castrates do not develop seborrhea, acne vulgaris, and premature or common baldness. Give these same men male hormone therapy in the form of methyl testosterone or testosterone proprionate and they develop seborrhea, comedones, and acne vulgaris simulating conditions seen in sexually mature men.

Max Joseph[12] states that baldness is a sex characteristic of men and occurs where there is seborrheic soil. He states that it is due to an abnormal process of cornification in which superficial horny scales retain their nuclei and remain soft. Parakeratosis of the outer root sheath of the hair occurs with subsequent hairfall. Some other German workers state that there is a relationship between cholesterol metabolism and growth of hair; namely, that in health sebum contains a high cholesterol content with subsequent diseased hair and alopecia.

Cederborg[12] of Helsingfors believes that in severe cases of hair fall there is seborrhea and an infective parakeratosis (pityriasis); that there is an initial specific microbacillus infection of the scalp. He believes there is an underlying general toxemia such as alcoholism or syphilis and various local infections such as oral sepsis, biliary pathology, genito-urinary infections or acute infections such as influenza, typhus, erysipelas, or acute local infections.

PATHOLOGY

Ormsby and Montgomery[13] state that the histopathologic picture of seborrheic dermatitis is not diagnostic. There is hyperkeratosis as well as parakeratosis, intracellular and intercellular edema of the epidermis, slight to moderate acanthosis, papillomatosis, dilation of the superficial vessels in the cutis, and a perivascular infiltrate consisting of polys, lymphocytes, and at times some plasma cells. Spongiosis serves to differentiate it from psoriasis, which it may closely simulate.

CLINICAL DESCRIPTION

Darier[14] gave an excellent clinical description of seborrheic dermatitis:

1. Seborrheic dermatitis of the scalp is evidenced by a dry scaling dermatitis (dandruff) but which may also be erythematous and oozing. Similar changes may also occur on the eyebrows and eyelid margins. The nasolabial folds, post-auricular folds, and external ear canals may also be involved.

2. Figurate seborrheic dermatitis sites are at presternal, interscapular and hair margin areas. The initial lesion is a dry red papule or group of papules. By addition of new papules the lesion spreads peripherally, leaving a central, fawn-colored, greasy scale.

3. Pityriasiform seborrheic dermatitis shows lesions that are dry scaling patches, not unlike those seen in pityriasis rosea, and occurs on the chest, back, abdomen, and occasionally the arms. The dermatitis is symmetrical and involves the flexures and palms.

4. Perifollicular seborrheic dermatitis is manifested by a subacute follicular, papular dermatitis, seen on the presternal and interscapular areas, and is present usually on a hyperhidrotic patient.

5. Psoriasiform seborrheic dermatitis presents itself as a papular dermatitis involving primarily the seborrheic areas. Clinically it is difficult or impossible to distinguish from a true psoriasis.

6. Exfoliative seborrheic dermatitis is marked by follicular papules which coalesce and subsequently desquamate, involving large areas of the skin. It may occur in secondarily infected areas which are overtreated.

DIAGNOSIS

Seborrheic dermatitis in general may be differentiated from other forms of dermatitis and from eczema by its origin in the scalp, its oily secretion, crusts, yellowish color and sharp outline of its lesions, its tendency to spread peripherally in circinate outlines and its lack of marked subjective symptoms, except for itching.

DIFFERENTIAL DIAGNOSIS

Psoriasis: This disease is at times difficult to differentiate from seborrheic dermatitis. In the latter, the flexors rather than the extensors are usually affected. The oily character of the scales and crusts, the yellowish color, the greasy and scaly center of circinate lesions undergoing involution, and general course of the eruption also will usually be enough to distinguish the disease.

Pityriasis rosea: This disease may present appearances similar to those of seborrheic dermatitis of the trunk and extremities. These lesions have ill defined frayed borders, the character of the scales are nongreasy, enlarging rings are dry and fawn colored in the center, and no scalp lesions are present, as a rule. The infection runs a more or less acute course of six to eight weeks.

Lupus erythematosus: This disease usually affects the face but may be present on the scalp and body. However, more characteristic would be the tenacious and dry scales and scarring produced by the lesions. Contour of the lesions are well defined. If the lesions persist after a fair therapeutic trial for seborrheic dermatitis, consider lupus erythematosus, especially lesions of the scalp.

Trichophyton corporis: This disease often appears on the face and may be mistaken for

seborrheic dermatitis but there is a distinct elevation of the borders, often with vesicle formation, and there is clearing in the center. Scrapings of the borders of the lesion will often prove fungus etiology. The same is true of tinea cruris, except clearing in the center is not pronounced nor necessarily present, and diagnosis should be made on finding the fungus.

Roseolar syphilis: A careful history and serology should rule out this disease.

Erythrasma: This disease is limited to the intertriginous areas. Scrapings of the lesions reveal the fungus under oil immersion. The lesions are reddish to orange colored, scaly and have elevated borders.

Tinea capitis: This disease, known commonly as ringworm of the scalp, usually occurs in children prior to puberty. Under the Wood's light the patches usually fluoresce green, broken off hairs are found, and the fungus may be found on the hairs or cultured from them.

TREATMENT

Treatment of seborrheic dermatitis may be divided into four categories:[1]

1. Prophylactic.
2. Anti-infectious.
3. Anti-seborrheic.
4. Anti-allergic.

1. Prophylactic: This involves liberal use of a mild soap and water several times daily. For a drier skin use a superfatted soap or new type wetting agent soap.

Cleansing creams are usually contraindicated. Cleansing of the scalp is essential every fifth night for the average case. In more severe cases shampoo of the scalp every second or third night would be more beneficial.

At the earliest flaking of the scalp, institute anti-seborrheic measures; one must pay attention to dietary errors, particularly overeating and overdrinking. Search for metabolic pathology. Prophylaxis is of most value during adolescence and where there is poor hygiene.

2. In case of pyogenic complications, treat these before treating the seborrheic dermatitis. One may use 5 percent ammoniated mercury ointment or D'Alibour's solution. Do not use a sulfonamide or penicillin ointment because of possible skin sensitization qualities which these drugs possess.

If there is much weeping use continual cold compresses of any one of the following: 4 percent boric acid solution; Potassium permanganate solution 1:10,000; Silver nitrate solution 1:500; or Burow's solution 1:20. Cover the compress with oiled silk and replenish the solution as needed.

3. Use antiseborrheic measures after the pyogenic infection is controlled. For local use Unna and Winkler[15] advise, in order of merit, sulfur, resorcin, chrysarobin, ichthyol, salicylic acid, pyrogallol, mercurials, and tar. The various areas differ in response to therapy. Scalps with short hair respond well to combinations of sulfur and salicylic acid, 3 percent each, in an ointment base such as petrolatum, lanolin, eucerin or a wetting agent base. Scalps with long hair use 70 percent alcoholic lotion containing resorcin and salicylic acid, 1.6 percent each; mercuric chloride 0.08 percent; and castor oil 1.2 percent. For blonds replace resorcin with chloral hydrate.

Seborrheic dermatitis of the external ear is difficult to treat. Use 10 percent ichthyol in normal saline solution and lightly pack in the ear. When the edema of the ear canal subsides use 10 percent ichthyol in glycerine. Cole[16] feels that for retroauricular areas that are fissured one may use liquor carbonis detergens 20 percent; hydrargyri ammoniate 3 percent, in equal parts lanolin and petrolatum. If sensitive to mercury, use bismuth tribromphenate, N.N.R.

The glabrous skin responds, if it is very oily, to sulfur 2 percent, resorcin 0.5 percent, in calamine or neocalamine lotion. Drier skins respond to sulfur, 0.5 percent to 1 percent in calamine or neocalamine liniment. Some prefer sulfur 1 to 2 percent in an emulsion base for use on the face. Articular folds respond well to crude coal tar, 0.2 percent to 0.5 percent in a lanolin, unguentum zinc oxide base. Sulfur irritates intertriginous areas and burns on genitalia. Use calamine liniment or liquor carbonis detergens 10 to 20 percent on these areas. In seborrheic dermatitis of the eyelids use 1 percent to 2 percent yellow oxide of mercury ointment or a mild crude coal tar 0.25 to 0.5 percent. Ultraviolet light is sometimes a good therapeutic measure. Use a mild erythema dose three times weekly with local therapy.

For the psoriasiform type of seborrheic dermatitis one may use a 3 percent to 5 percent crude coal tar in Lassar's paste, combined with ultraviolet irradiation three times a week.

X-ray therapy may be used in resistant cases of seborrheic dermatitis. Seventy-five roentgen units applied to the affected areas every five to seven days for six doses usually suffices. One may repeat another six doses in six months. The total dosage should not exceed twelve hundred roentgen units for any one area, except hairy areas, in which case three to four hundred roentgen units should not be exceeded.

Permanent epilation of hair or severe x-ray burns of the skin may result from over-irradiation and this is to be avoided. Care should be taken, especially about face centers, of exit dosage and back scattering of x-rays. It is of prime importance that one experienced in the use of x-ray irradiation should apply these treatments.

General factors of health are important. Fresh air, sunshine and rest should be advised. A low

fat, low carbohydrate diet and avoidance of spices and carbonated drinks is helpful. A high intake of vitamin B complex, especially pyridoxine and riboflavin, is considered by some to be beneficial. Alkalinization of the urine likewise is thought to be beneficial. Estrogenic hormone is of benefit occasionally if the endocrine system is at fault.

4. In anti-allergic treatment consider a suspension or extraction of causative organisms, especially pityrosporum ovale for desensitization.

SUMMARY

1. Seborrheic dermatitis is a common dermatosis and is manifested by patches of greasy scaling. It usually affects the scalp first and occasionally spreads to the seborrheic areas of the face and scalp.

2. Some investigators believe a triad of organisms are responsible in the etiology of seborrheic dermatitis, the triad being:

(1) Pityrosporum ovale (bottle bacillus of Sabouraud and Unna).

(2) Microbacillus of Unna and Sabouraud (Bacillus acne of Gilchrist).

(3) Staphylococcus epidermis albus of Welsh (the grey bacillus).

Others speak of the greater activity of the sebaceous glands, dietary errors, constitutional background, and hormone factors.

3. The various clinical manifestations of seborrheic dermatitis are described.

4. Seborrheic dermatitis in general may be differentiated from other forms of dermatitis and from eczema by its origin on the scalp, its oily secretion, crusts, yellowish color, sharp outline of the lesions, its tendency to spread peripherally in circinate outlines, and its lack of marked subjective symptoms, except pruritus.

5. A differential diagnosis between psoriasis, Pityriasis rosea, lupus erythematosus, trichophyton corporis, roseolar syphilis, erythrasma and tinea capitis is considered.

6. The treatment of seborrheic dermatitis is described in four categories, namely: (1) prophylactic, (2) anti-infectious, (3) anti-seborrheic, and (4) anti-allergic.

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Under a By-laws change of last year, members of committees of the Indiana State Medical Association are now appointed for a term of one year. Heretofore, some committee members were named for a specific number of years. The change was made so that the president could name the committees to serve during his year in office, without being encumbered by appointments made by predecessors.

AXILLARY METASTASIS AS THE FIRST SIGN OF MALIGNANCY OF THE BREAST

James A. McClintock, M.D.*

MUNCIE

IN THE YEARS since Halsted, Willy Meyer and Handley popularized the radical excision of the breast for malignancy, a tremendous number of cases have been reported. Most papers have emphasized the presence of a mass in the breast, retraction of the nipple or dimpling of the skin as early signs of cancer. In the average case this is true. Recently we saw a case in which the attention was drawn to the breast by a discrete, firm, axillary mass. Repeated examinations of the breast showed no major pathology, yet the breast was later shown to contain a minute primary lesion, with the axillary metastasis as the first sign of malignancy.

Case History: The patient was a 66-year-old colored female who had been seen in the G.U. Clinic intermittently since 1941 because of chronic cystitis and recurrent urethral caruncle. On a routine visit to that clinic on January 19, 1949, the patient complained for the first time of a lump under her right arm, which to her knowledge had been present two and one-half weeks. The patient was referred to the Tumor Clinic where examination confirmed the presence of a firm, discrete, nontender mass (5x5x4 cm.) at the lower border of the right axilla, just at the edge of the pectoralis major muscle. The mass had not changed in size during the time that the patient had observed it. Except for slight inguinal adenopathy, there were no other palpable masses. The right breast was thoroughly examined by palpation and transillumination by a number of competent observers who comprise the tumor board. No lesion of any kind could be found. It was the opinion of the tumor board that the mass probably represented a fibroadenoma in aberrent breast tissue, although the possibility of metastasis from an undisclosed mediastinal or extremity lesion was considered. The patient was admitted to the hospital for study and excision of the mass.

Laboratory findings were all normal. Chest x-rays showed the heart to have an increased transverse diameter, but were not suggestive of mediastinal neoplasm. The past history, family history and inquiry by systems were not contributory. The patient had experienced an early menopause thirty-two years before, following the birth of her fourth child. She had nursed all four children with no breast complications. Physical examination was normal except for the previously described axillary mass. There was no demonstrable extremity lesion and the breast, aside from the expected atrophy, showed no change. No secretion could be expressed from the nipple.

On January 29, 1949, under general anesthesia the patient was prepared and draped as for a radical mastectomy. An incision was made directly over the axillary mass and it was removed as an excision biopsy. Gross study showed that the mass consisted largely of two lymph nodes (3x2.5x2 and 4.5x3x3 cm.). Both appeared to be well encapsulated. On cut surface they were firm and pearly white, and seemed to contain tumor tissue. Frozen microscopic sections were prepared which showed the tumor to be malignant, but were not diagnostic as to the type of malignancy. It was decided on the basis of these findings that a radical excision of the axillary lymph nodes should be accomplished and, on the basis of probability, that the right breast should also be removed.

A radical mastectomy, using a Willy Meyer type of incision, was done. The specimen was taken at once to the pathology laboratory, where it was examined minutely. No further grossly malignant lymph nodes were found. The breast was carefully palpated after cutting it in thin sections and finally a small firm nodule 3 mm. in diameter was isolated under the edge of the areola in the upper outer quadrant. It was removed for study. No other masses were found.

Examination of the permanent microscopic slides showed the architecture of the lymph nodes to be destroyed by the invasion of neoplasm. The cells were large and pale with granular cytoplasm and large round vesicular nuclei and distinct nucleoli. Many mitotic figures were present and there were occasional tumor giant cells. Reticulum stains showed interlacing fibers between the cells, the whole picture being characteristic of reticulum cell sarcoma. (One pathologist who saw the microsection in consultation suggested that the lesion might be an atypical carcinoma.) The tiny lesion found under the areola was composed of identical tissue.

The patient was given postoperative roentgen therapy (6400 r. measured in air distributed through four ports). Aside from some edema of the arm, the patient has had an uneventful course in the first seven postoperative months.

CONCLUSION

An interesting case is presented, with large axillary lymph nodes as the first sign of a minute reticulum cell sarcoma of the breast.

* From the Department of Surgery, University of Louisville, School of Medicine, Louisville.

PENTOTHAL SODIUM IN UROLOGICAL PROCEDURES*

Report of One Thousand Cases

W. L. Wissman, M.D. and Wm. B. Sigmund, M.D.

Columbus

IN OUR experience sodium pentothal, 2½ per-cent solution, in combinations with oxygen, nitrous oxide and curare, has been a most satisfactory basic anesthetic agent. Urological procedures present certain anesthetic requirements differing from other fields of surgery. We feel that pentothal met these requirements. Among the factors governing these requisites, in our series, were the high incidence of aged patients, the presence of electrical sparks from the Bovie unit, need for early ambulation, re-anesthetizing of many of these patients, degree of relaxation necessary for surgery, and the techincal difficulties of administering the agent.

Although premedication is a subject unto itself, certain observations must be made with reference to urological patients and pentothal. Our criterion for premedication was made after individual evaluation of the patient and the surgery contemplated. Arbitrarily, in patients past sixty, demerol, milligrams fifty to one hundred, was given with atropine, grains 1/150, exact dosage of demerol depending upon the size and general physical state of the patient. In our eleven cases of momentary laryngeal spasm it was felt that inadequate premedication had been given or that stimulation of the patient before reaching surgical plane anesthesia was responsible. In the younger, so-called robust individuals we used morphine sulfate, grains ⅙ to ½, and atropine, grains 1/150, again depending upon age and physical state for the exact dosage. We observed that we had better anesthesia in the aged if the premedication was given intramuscularly and we insisted that an inch and a half needle be used to insure the medication getting into the muscle of the deltoid or the gluteus maximus.

The average age of the patient on whom surgical urology was performed was 57.6 years of age. The diseases most commonly requiring surgery were entities that occurred in the fifth, sixth and seventh decades of life.[1]

Much has been written about the pharmacology and the eventual breakdown of pentothal in the human body. Some authors believe that the liver plays an important role in the catabolism of this drug. As a result, it has been suggested that such an agent should not be used in the patient with poor liver function. Further, it has been said that the aged do not tolerate pentothal well. In our experience such has not been the case. In one hundred and eighty-seven instances patients were in the sixth, seventh and eighth decades of life and the average amount of pentothal for this group used was 1.3 grams. In these, as with all surgical procedures, continuous oxygen was given. Often nitrous oxide-oxygen, fifty-fifty combination, was used. On occasions curare was added. There were eighteen occasions when plasma and whole blood were used to combat developing shock. However, in only one case was the patient considered in extremis. He recovered after a rather stormy course and to our knowledge is living and well today. We were not aware of any postoperative atelectatic or pulmonic stasis states in this aged group. Duracillin was given prophylactically, one cc. every 12 hours for five days, and early ambulation was encouraged whenever possible. The postoperative circulatory status of these patients has not been appreciably altered.[2] Hypotensive states such as those following spinal anesthesia, necessitating vasopressor drugs, have not been encountered. No instances of venous thrombosis, embolism, paralytic ileus, or acute urinary retention have appeared in our series. The early return to normal physiological functions, such as ambulation, normal nutritional intake and excretory habits, have eliminated the need for routine or frequent parenteral supportive measures.

From the surgeon's viewpoint relaxation of the patient is essential for his manipulations, not to mention his state of mind. This degree of relaxation is less than in intra-abdominal operative procedures. Pentothal anesthesia supplied adequate relaxation for the procedures in this series. Sodium pentothal has been found to be an unusually satisfactory agent for those patients who require two or three anesthetics during a comparatively short period of hospitalization; for example, on the patient where endoscopic manipulation is indicated to encourage the passage of a ureteral calculus, and in those patients where diagnostic study is followed by a definitive cystoscopic operative procedure within a few days. In these patients there is surprisingly little apprehension towards additional anesthesia, because they have not experienced the unpleasant reaction encountered with the induction of inhalation anesthesia or the physical and psychic trauma resulting from difficult intrathecal anesthesia. Neither have they experienced any of the unpleasant postanesthetic

* Presented before the Indiana State Society of Anesthesiologists, at Indianapolis, March 12, 1950.

TABLE I

Operation	1946	1947	1948	1949	Total
Biopsy	4	3	4	1	12
Circumcision			2	1	3
Cystoscopy	90	170	238	233	731
Cystotomy		2		1	3
Fulguration	25	9	20	16	71
Incision and Drainage		1	2		3
Laparotomy, Exploratory				1	1
Litholapaxy	3	1			4
Lithotomy	1	1	2		4
Lithotrity	1	2		1	4
Meatotomy	3	3	5	1	12
Orchidectomy	4		4	6	14
Plastic Repair			1		1
Radical Cure Hydrocele		1	2		3
Removal, Calculus	1	5	5	1	12
Removal, Foreign Body, Bladder			3		3
Repair, Ureterocele			1		1
Resection, Prostate	32	25	35	15	107
Resection, Tumor	2		3	1	6
Urethrectasia	1		1	1	3
Ureterolithotomy		1			1
Urethrotomy			1		1
TOTAL OPERATIONS FOR YEAR	167	224	328	281	1000

complications, such as nausea, vomiting, acute retention, priapism, vague backache or abdominal distention. Our patients were able to take fluids and nourishment usually within a few hours following surgery. Those patients who had received an inhalation or a spinal anesthetic for a nonurological procedure previously often expressed their decided preference for intravenous sodium pentothal.

In all endoscopic surgical procedures employing multiple spark gap machines (Davis-Bovie) the potential hazard of vapor combustion with gas-oxygen-ether mixtures is always present. Also added to the hazard of explosive mixtures is the possible activation by radiographic equipment. None of these hazards is present with the use of pentothal.

Even though the technique of intravenous pentothal induction and conduction is relatively simple, one should not be misled by its simplicity and forget that proper administration of intravenous anesthesia requires careful evaluation of the patient preoperatively and during the conduction. In our experience a relatively rapid induction to the first stage of surgical plane anesthesia has produced a smoother course than by slower induction. Furthermore, we observed that those patients who have been put into first stage surgical plane and allowed to come up do better than those who are put into the lightest plane possible that was compatible with the operative procedure. The difficulties one encounters in lumbar punctures present formidable problems of achievement in the aged and arthritic patient. None of these experiences is true with pentothal.

In summary, pentothal has certain distinctive advantages as an agent in urological surgery. The ease of administration, the elimination of explosive hazards, the absence of postoperative pneumonic and atelectatic states, avoidance of circulatory collapse, the ease with which early ambulation can be accomplished, and the lack of psychic trauma are among these advantages.

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WHO ARE OPPONENTS OF SOCIALIZED MEDICINE?

It is frequently argued that most of the opposition to either socialized medicine or government-controlled medicine originates within groups whose motives are entirely selfish, and who are completely without interest in the welfare of the masses of people. That argument can hardly withstand the light of fact. Current proposals for government medicine have met with the formal opposition of 15 state legislatures, and the amazing total of 10,000 national, state and local organizations. Among these are the General Federation of Women's clubs, the American Legion, the Veterans of Foreign Wars, the American Bar association, and the American Farm Bureau.

To say that organizations of this character are inspired by the selfish considerations of a few people is to say the ridiculous. They represent millions of individuals, of all political faiths, and of all the economic levels. They agree on the issue of government medicine for one reason—their belief that it would reduce the quality of medical care, that it would place a tremendous and unnecessary burden on the taxpayers, and that the growth of our established system of medical care, along with the many voluntary insurance plans, offers the best available solution to our health problems.

Those who would socialize, or otherwise regiment the practice of medicine, work on the theory that if a roof leaks, the solution is to burn down the house. That there are gaps in our medical care system goes without saying—and doctors are among the first to realize this, and to take measures to close them. In recent years, enormous progress has been made. The future will bring greater progress—if the hand of the politician can be kept off the back of the doctor.

—*New Castle Courier-Times*

ACRODYNIA FOLLOWING THE USE OF BICHLORIDE OF MERCURY DIAPER RINSE

Report of Two Cases

G. E. McCoy, M.D.

Muncie

RECENTLY Warkany and Hubbard[1] have shown conclusively that there is a relationship between heavy metals, especially mercury, and the condition known as acrodynia. In 1948 Warkany reported 20 cases of acrodynia. Out of this group 18 had mercury in the urine; 15 out of the 18 had over 50 gamma of mercury per liter. Since then several additional cases have been reported, all having mercury in the urine. In two cases in which the subjects were thought to have acrodynia, no mercury was demonstrated in the urine. Only two of the control series had as high as 51 to 100 gamma of mercury per liter without clinical evidence of acrodynia.

Bivings and Lewis[2] and Elmore,[3] working on the basis that acrodynia might be due to heavy metals, especially mercury, treated their patients with BAL (British Anti-Lewisite) with rapid clinical improvement. As the patient improved clinically the amount of mercury in the urine became less.

Between March and September of 1949 Doernbecher Children's Hospital had two patients who were thought to have a mild form of acrodynia. The urines were sent to Doctor Josef Warkany, who in turn sent them to Kettering Laboratory in Cincinnati for mercury analysis. The initial specimen of one patient had 1680 gamma; that of the other patient 120 gamma of mercury per liter of urine. In both instances, the child had a severe diaper rash with ulcerations of the skin. The rash was resistant to the usual procedures, and bichloride of mercury diaper rinses had been advised by the physicians and continued by the parents for several months. Investigation showed the mercury must have come from the diaper rinses.

CASE REPORTS

A nine-months-old, white male was first admitted to Doernbecher Hospital on April 26, 1949. The child was referred to Doernbecher Hospital as a possible acrodynia, with the history that the child was perfectly well until three weeks prior to admission, with the exception of a diaper rash, which seemed resistant to all treatment. This rash had been present for the previous five months and, according to the mother, bichloride of mercury diaper rinses had been used.

Department of Pediatrics, University of Oregon Hospitals and Clinics.
Doernbecher Memorial Hospital for Children.

Four days prior to admission the patient's illness had been characterized by increasing irritability, profuse perspiration, and cold hands and feet. Three days later the child began to break out in a red macular rash, which was most marked about the face, particularly perioral in distribution.

Physical examination revealed the following: The hands were very cold, red, and slightly swollen. The child was damp and clammy from perspiration. The feet were affected but less extensively than the upper extremities. There was a diffuse erythema of the diaper area. The right tympanic membrane was injected but not bulging, and there was little mucoid discharge from the nostrils. The child was on an elimination diet of goat's milk. Blood pressure on admission was 150/100 in the left arm, temperature was 98, and pulse 160.

Laboratory examination revealed a urine which was essentially normal to routine analysis. Examination of the blood revealed 103 percent hemoglobin, (14.2 grams per 100 ml.) and 5.4 million erythrocytes. Leukocyte count was 19,050 with 51 percent neutrophils, 1 percent eosinophils, 43 percent small lymphocytes, and 5 percent stab cells; sedimentation rate was 1 mm. in 1 hour. Serology was negative and the blood type was II (A) Rh positive. Radiograph of the chest was essentially normal.

Since this was a suspected case of acrodynia, a urine specimen was tested for mercury determinations, and no mercurous or mercuric ions were found.

Throughout the first few hospital days the child was exceedingly irritable, perspired freely, and the erythema seemed to spread over a larger area. The hands and feet remained cold, the appetite was quite variable, and on occasions the patient vomited. The child lost approximately one kilogram of weight during his hospital stay. In spite of the clinical findings, which were not severe, it was felt that the most likely possibility was acrodynia. The prolonged contact with bichloride of mercury diaper rinses was thought significant. For that reason urine specimens were sent to Dr. Josef Warkany at the University of Cincinnati Research Foundation for mercury determinations. (See Chart No. 1.) Because of the time element (about 10 days) of sending urine specimens from

CHART I

Date	Gamma of Hg./liter	Total Amount of B.A.L.
4-30-49	1680	None
5- 9-49	1040	1.5cc.
5-11-49	390	2.5cc.
5-12-49	390	2.5cc.
5-17-49	720	6.2cc.
5-27-49	620	6.2cc.
5-28-49	620	Second course of B.A.L. started
5-31-49	Sample broken	6.2cc.

Oregon to Ohio, the actual analysis of the urine and receiving a report, we were guided in this instance by the clinical course of the patient. The reason for the marked fluctuations in the concentration of mercury in the urine is unknown, but not unusual.

The first urine specimen was collected on April 30, 1949; and it contained 1680 gamma of mercury per liter. The child seemed somewhat better in the hospital and was discharged on May 3, 1949, on a regular diet and vitamins. Sulfonamides were prescribed for the incipient ear infection.

On May 8, the child was re-admitted. The mother was hysterical and the child was very irritable. The extremities were cold and covered with perspiration, and it was decided upon admission that a trial course of BAL should be given. BAL therapy was instituted in accordance with the direction of Bivings and Lewis. In a period of six days the child showed marked improvement. Irritability had disappeared, skin of the toes began to peel, and the extremities were not as cold and clammy as prior to the BAL therapy.

The child was discharged the second time on May 17 and re-admitted on May 26. Additional urine samples were obtained upon admission; there was still clinical evidence of acrodynia, and it was felt that the child should be given another course of BAL therapy. This was instituted and completed. The child was discharged for the third time on the second of June, clinically well, but still excreting relatively large amounts of mercury in the urine. The child was again seen as an outpatient on June 30, at the request of the hospital staff. He was clinically well, gaining weight, not irritable, and extremities not cold nor erythematous. A urine specimen was not obtained at this time.

SECOND CASE

A thirteen-months-old, white female was well until March, 1949, when she developed a rash on the buttocks which cleared after two months of local treatment, using penicillin ointment, sulfa ointment, and gentian violet and bichloride of mercury diaper rinses. The patient was then well for approximately one week, after which she suddenly developed a pulmonary infection, which was characterized by excessive production of mucus in the pulmonary tree and as a result developed marked difficulty in breathing. The pulmonary infection recurred many times, and each time the patient was hospitalized without a definite diagnosis being made. She was finally referred to Doernbecher Memorial Hospital for Children for further diagnostic studies. Before she was transferred cultures were made of the tongue lesions, of the stool, and of the urine, all of which revealed Monilia albicans.

On admission to Doernbecher Children's Hospital it was found that she had a temperature of 101, respiration of 30, blood pressure of 98/68, and a pulse of over 120 per minute. She was very dehydrated and very restless. She also had a generalized skin eruption most marked about the perineum, which itched severely. The child was also noted to be extremely flaccid, could not sit up by herself, and rarely cried. It was also noted that there was a fair degree of redness of both hands and of both feet. Physical examination otherwise was as follows: Examination of the mouth and pharynx revealed scarring of the tongue, which was the result of a severe Monilia albicans infection, previously mentioned. The pharynx also contained a considerable amount of very thick, whitish mucus. The tonsils were apparently normal. The chest was symmetrical, but there was poor excursion on breathing; it was resonant to percussion, and no definite areas of consolidation were noted. However, many rhonchi were heard throughout the entire lung fields. The heart was normal in size; sinus rhythm was present; no murmurs were heard. The extreme softness of the abdomen reflected the generalized malnutrition. The genital area was normal except for the rash previously mentioned. Extremities were normal except for the erythema of the hand and feet and marked hypotonia. There was also suggestive scaling between the fingers and the toes. Lymph nodes were all normal. Muscle tone was extremely poor. Reflexes were somewhat hypotonic. The remainder of the physical examination was normal.

Blood studies on admission showed 14 grams of hemoglobin, 4.5 million erythrocytes, 9,400 leukocytes (which during her hospitalization rose to 19,000). Differential showed 53 percent neutrophils and 39 percent small lymphocytes. Sedimentation rate was within a normal range. The blood total proteins were 6.3 grams, with a normal albumen-globulin ratio. Serology was negative. The Mantoux test was negative, and the Paul-Bunnell reaction was negative; typhoid, paratyphoid and Brucella abortis agglutinations were all negative. The urine was within a normal range. The spinal fluid was normal. Skin scrapings taken in the perineal area revealed the presence of Monilia albicans.

The stool was found to contain normal quantities of trypsin. Radiographs of the chest, long bones and skull were all normal, and the cardiac shadow was within normal limits. The lung fields showed no definite parenchymal lesion. However,

there was a prominence to the right hilar shadow which was most likely due to lymphadenopathy on an infectious basis.

Patient was laryngoscoped, and a large amount of white, sticky, frothy material was aspirated. This was cultured, and found negative for fungi. A neurological examination was negative. A muscle biopsy was negative. Because of the presence of the marked flaccidity, the irritability, and the skin lesions, as well as the malnutrition, and erythema of the hands and feet, the possibility of this being acrodynia was raised and a urine specimen was sent to Dr. Josef Warkany at Cincinnati, who reported the presence of 15 gamma of mercury in the sample, a level of 120 gamma of mercury per liter, which is abnormally high.

The patient was given "actidione" (an experimental fungicide supplied by Eli Lilly Company; there was no mercury used in the production of "actidione"). A considerable improvement of the skin lesions was noticed but no improvement was observed in the chest condition or increase of muscle tonus. A tentative diagnosis of acrodynia was made and additional urinalyses were made, the results as shown in Chart No. 2.

CHART II

Date Spec. Collected	Gamma of Hg./Liter	Treatment
7-29-49	120	Non-Specific
8-18-49	20	Non-Specific
8-22-49	90	Non-Specific
8-30-49	60	Non-Specific

The patient was sent home on a high protein diet. In general the patient's condition was not markedly improved. A three month follow-up examination revealed the child to be improving without specific treatment. She was then walking and the chest was clear on physical examination.

DISCUSSION

It has been previously pointed out that many children have received mercury compounds without the development of such a syndrome as acrodynia. Certainly there is little relationship between the actual amount of mercury in the urine and the illness of the child.[4] In view of this lack of relationship, one certainly must consider acrodynia as based on unusual sensitivity to heavy metals, especially mercury. It might also be considered that these patients have a "constitutional threshold" for mercury. When this threshold for mercury has been exceeded, and it varies from patient to patient, the symptoms become manifest. The wide range of mercury in the urine of cases reported by Warkany[1] and in the two cases here reported would seem to confirm this impression. Other similar situations might be the pollen count in relation to hay fever or external stimuli to children susceptible to convulsions.

Bichloride of mercury as a diaper rinse has been used for many years without any known ill effects to the patient. It should also be said that in many cases bichloride of mercury has been effective in treating diaper rashes. On the other hand, the inherent danger of accidental ingestion of the tablets or of acute mercury poisoning from skin absorption should be considered. This is a known objection to bichloride of mercury packs used to clear up infected burns or ulcers. The possibility that acrodynia might also be produced in this manner must be considered. Now that there are many effective new products on the market for the treatment of diaper rash, the use of bichloride of mercury as a diaper rinse should be completely abolished.

SUMMARY

1. Two cases of acrodynia are reported following the use of a bichloride of mercury diaper rinse in the treatment of a diaper rash.

2. Mercury was found in the urine in each case.

3. BAL was used in one patient with questionable results.

4. Bichloride of mercury as a diaper rinse should never be used.

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OREGON JUDGE OK's ORGANIZED MEDICAL GROUP

Federal Judge Claude McColloch recently ruled that Oregon's organized medicine has not violated the Sherman anti-trust act in its prepaid service.

The government charged that the State Medical society, a number of county societies, and several physicians sought to monopolize the field of prepaid medical care by refusing to deal with private agencies and by disciplining physicians who did deal with them.

"I hold that the Oregon physicians service is not a conspiracy, but rather an entirely legal and legitimate effort by the profession to meet the demands of the times for broadened medical and hospital service, eliminating the evils of privately owned concerns as well as the element of private profit," Judge McColloch wrote.

Chicago Daily Tribune

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Editor Emeritus: E. M. Shanklin, M.D., Hammond, Indiana

Editor: Frank B. Ramsey, M.D., 201 Hume Mansur Building, Indianapolis 4, Indiana.
Associate Editor: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana.
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AMERICAN RED CROSS

IN MAKING civilian defense plans there are many unknown and indeterminate factors to be considered. However, there is one fundamental fact that may be stated with certainty. In the event of an atomic attack on a large city there will not be enough doctors to care for the casualties.

Even though all the medical personnel were spared by the explosion, and even if all the physicians in the entire state could be utilized in one disaster, the proportion of patients to treat would be overwhelming.

The solution to this problem is extensive training of nonmedical personnel in the care of blast and burn injuries. How many people should be so trained is a question of little moment at the present time. It is apparent that as many as can be trained in a reasonable time will not be enough. It is also apparent that an oversupply of trained individuals would not do any harm, and that if everyone had instruction in first aid there would still not be too many.

The American Red Cross traditionally has been the organization to which Americans look in time of disaster. In the present crisis the Red Cross has undertaken the first aid training of all persons who volunteer for such instruction. This is a large order and its successful completion will require the cooperation and assistance of all members of the medical and allied professions.

The scope of the program will necessarily be large, since not only must a large number of citizens receive training, but the training must be given over an extensive area. As many as possible of the population of a target area should be instructed, and in addition courses should be given to people who live at considerable distances, since many of the casualties will be evacuated and treated in surrounding communities.

The Red Cross has been far-sighted in emphasizing its courses in Home Nursing. If we are ever called on to care for atomic bomb victims, a great many of the injured will be treated in homes, and most of the nursing will be done by nonprofessional personnel. A widespread knowledge of the fundamentals of home nursing will be a necessity.

The major responsibility for national coordination of all phases of the blood bank program has been assigned to the Red Cross. The cooperation of all other blood banks is needed to make this program effective. Since whole blood is not storable for long periods of time, the blood bank system of the entire country must be built up by training

technicians, so that the tremendous amounts of blood required may be obtained and processed after the need for it has developed.

The American Red Cross is qualified by organization, training and experience to take the lead in these great responsibilities, but will require the wholehearted cooperation of all other agencies in order to accomplish its task.

GENERAL PRACTITIONER AWARD

THE House of Delegates on September 25 selected Dr. John William Strange of Loogootee for the General Practitioner Award, and as Indiana's nominee to the American Medical Association for the honor of national General Practitioner of 1950.

Doctor Strange was properly honored at the annual banquet and was presented with an oil painting, "Beeches on the Hillside," a work of the celebrated Brown County artist, L. O. Griffith.

Doctor Strange is 74 years old. He started his practice under primitive conditions many years ago, and during the years has found his travel reverting to the same primitive conditions many times. His practice is located in a section where flood waters are all too common. Many citizens of the community surrounding Loogootee have expressed their gratitude for his trips under difficult circumstances when his services were needed.

Despite a busy professional life, Doctor Strange has found time and energy to devote to his obligations as an ordinary citizen. He has been a civic leader in his home town and served for one term as its mayor.

His zeal and enthusiasm for the practice of medicine is illustrated by the fact that he still conducts a very active practice, and accepts calls during all hours of the day and night. On the day he attended the convention he arose at 6 A.M. and made three house calls before departing for French Lick.

DIABETES DETECTION DRIVE

THE WEEK of November 12 to 18 will be utilized this year for the annual diabetes detection drive. The Committee on Diabetes of our state association has made plans in conformity with those of the American Diabetes Association, and is urging all physicians of Indiana to participate in or cooperate with the drive in order to make it as successful as possible.

Diabetes mellitus is a disease which often exists without producing symptoms which are definite enough to bring the patient to the doctor. Mass surveys in the past have shown that there are about as many unknown diabetics in the United States as there are known ones.

Since the course of the disease is favorably altered by early detection and proper treatment, it is of especial advantage to discover diabetics before their symptoms are advanced.

The detection drive in 1949 diagnosed some 7,500 previously unknown diabetics in the United States. One city of 12,000 accomplished an 81 percent testing of its population and found 50 cases of diabetes which had hitherto been unrecognized.

Industries and businesses are becoming more and more interested in screening tests for chronic illness. Schools are also excellent sites for a mass diabetes survey. As the results of the annual diabetes detection drives become known, interest in them will increase from year to year.

LOS ANGELES BOOMERANG

Last month the City Council of Los Angeles passed an ordinance providing for the experimental use of some of the dogs which would otherwise be killed at the City Pound. The ordinance will be ratified by a referendum vote of the people on November 7.

The tentative Los Angeles victory followed closely on the heels of passage of a law by the City Council of Buffalo to save animals in that city.

In both cities vital research will soon move forward at a more rapid pace and medical teaching will improve.

How great an increase in work is to be expected is indicated by the fact that all of the universities, government laboratories, and private institutions in the Los Angeles area combined did not use as many dogs in a year, heretofore, as the University of Illinois does in a week.

In Los Angeles the antivivisection cult had won and didn't know it. Research was virtually at a standstill and medical teaching was seriously restricted. But the cult wanted to administer the coup de grace to medical science in Southern California and so campaigned for total prohibition of experimentation and prohibition of the use of unwanted pound dogs in research. This brought a long overdue counter-attack from the medical scientists and the civic leaders interested in public health.

The result was the victory for health work which every community can have if the advocates of medical science will merely act in concert.

Los Angeles has twice as many sympathizers with the antivivisection cult as the national average according to the survey of the National Opinion Research Center.

If the fanatics can be licked in Los Angeles they can be licked anywhere.

RALPH A. ROHWEDER, Ex. Secy.,
Bulletin, of the National Society for Medical Research

President's Page

THE CHALLENGE AT THANKSGIVING

DO YOU remember back, when you were a child, the coming of Thanksgiving meant to you a big dinner, with fancy fruits and nuts, and the gathering of all the family for the day? It was a happy time that we looked forward to from year to year. Food seemed a little more plentiful in those days and it was not uncommon to have several kinds of meats, and lots of pies and cakes, and, of course, everyone ate too much. That was Thanksgiving to us in our childhood.

And then as we grew a little older, and perhaps one of the family group had passed on and wouldn't be at the reunion any more, we began to have a changing concept of Thanksgiving. We came to appreciate how thankful we should be for those who are left, with whom we might join on this happy day. And we began to appreciate the bountiful table and the effort the ones had made who provided and prepared the feast. And sometimes the thought crept into our consciousness that perhaps we should be thankful, too, for the health which permitted us to be among those who could enjoy this happy occasion.

Finally, with a little more maturity and enlargement of our horizon, we began to comprehend a much deeper meaning in Thanksgiving Day. The Pilgrims at Plymouth Rock understood this profound feeling. Their lives had been filled with hardships, primitive experiences in relation to their very existence and the freedom of their souls. To be able now to work and strive, with the promise of liberty and freedom from the oppressions from which they had just escaped, was a cause of profound thanksgiving. No doubt all of us at times have felt this deep sense of our humbleness. We have had many things to be thankful for in our own lives here in America—for our great freedoms, unheard-of prosperity, and opportunities that exist perhaps nowhere else.

But things are changing around us now. Each of us has begun to sense that the old America is being taken from us. The easy, prosperous times of yesterday caused the apathy which is now behind the heartaches that real Americans are beginning to feel. And perhaps now we should be sincerely thankful for the challenge which will test us to see if we too will deserve the rewards which came to those at Plymouth Rock. Thankful for the challenge which will determine how strong we really are.

Alfred Edison

Medical Panorama by the Associate Editor

GEORGE KICKS KARL IN TEETH

George Bernard Shaw, 94-year-old dramatist, trips over some pebbles in his British back yard, breaks a thighbone, and is shipped to a nearby hospital for an operation.

The old rooster has been a Socialist since the Later Bronze Age or thereabout. Socialist medicine is now in full blast throughout Great Britain. All ordinary medical services are "free," meaning paid for out of taxes, so you get the pleasant illusion that it's costing you nothing when you accept such aid.

Does Shaw go in for Socialist medicine in this case? He does not. He's one of the rotten rich whom he has always professionally denounced, and stingier with his dough than almost any other living wealthy person. Nevertheless, he kicks old Karl Marx, founder of Socialism, in the teeth. Shaw demands a private room at $6.08 a day, for which he will have to pay out of his own fishhooked pocket, and specialist services, for which he will also have to pay.

When top-drawer Socialists like Shaw, Attlee and Bevin can't take their own brand of Socialist medicine, just how good or how desirable for anybody is that medicine?

—*New York Daily News.*

THE CARDS ARE DOWN

The Milwaukee Medical Times, for September 1950, contains an article on the Hess Report, by Dr. J. E. Habbe and William Stronach (Executive Secretary, American College of Radiology), which is both timely and clear-cut. It is, of course, concerned with "corporate practice" or "the hospital practice of medicine." In addition to outlining the evolution of the Hess Report and stating the principles involved, it quotes the manifesto of the American Hospital Association, of March 1950, which stated ". . . that radiologic, pathologic, anesthesiologic, and physiatric services are included properly in a patient's day of hospital care, and . . . resolved that services rendered by physicians in radiologic, pathologic, anesthesiologic and physiatric departments of hospitals be included in prepayment hospital service plan subscriber certificates." Dr. Habbe and Mr. Stronach comment as follows:

> Placing the A.M.A. and A.H.A. statements side by side we may clearly see that the cards have now been dealt on the table face up.
>
> It is neither expected—nor desired—that the adoption of the Hess Report should cause an over night revolution in present hospital-physician relationships.
>
> * * *
>
> All of us concerned with the care of the sick—in or out of hospitals—must continue our efforts to improve the quality of medical care rendered to patients. We should, however, use the guidance provided by the Report to bring our practices gradually into conformance with the principles enunciated by the A.M.A.
>
> * * *
>
> In our activities in the field of prepaid, non-profit hospitalization. and medical service insurance plans, we should continue to strive to eliminate all medical services from the former, and include all medical services in the latter. As the Hess Report states "One of the factors that have aggravated physician-hospital relationships is the inclusion of medical services in the contracts of voluntary hospital service plans—the American Medical Association has reaffirmed many times through its then Bureau of Medical Economics, its Judicial Council, and the House of Delegates the principle that hospital service plans should exclude all medical services and the contract provisions of such plans should be limited exclusively to hospital services, namely, room accommodations, bed, board, operating room, medicine, surgical dressings, and general nursing care."
>
> * * *
>
> Finally, we may profitably consider the statement of the Nebraska State Medical Association recommending that each hospital staff "appoint a small well-chosen committee on hospital and professional relations which should concern itself with ethics, responsibilities, standards, and contractural relations relevant to medical services provided within the hospital and to establish general policies relevant to such medical practices."

These ideas are entirely in line with the sentiment of our Indiana membership, but it is respectfully urged that sentiment alone is not enough. It is necessary to keep before us at all times concrete and definite guides for action. Furthermore, as stated long ago, and recently demonstrated, eternal vigilance is the price of liberty—AND DON'T FORGET IT!

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

THE A.M.A. SHOULD LOOK AHEAD TO A LONG FIGHT

The trustees of the American Medical Association apparently have counted up the returns from their costly investment in lobbying and propaganda against national health insurance, and are satisfied with what it adds up to. They have approved spending three million dollars more against what it suits their purposes to call "socialized medicine" and, according to the dispatches, to bring about an early vote on the issue in Congress. In this outline of strategy is reflected a vast amount of confidence, probably justified for the immediate future.

However, it is hard to agree with the suggestion that a vote in the Congress, however overwhelmingly against compulsory health insurance, will end the matter or deliver the knockout blow, the ultimate sockdolager, to the idea. Rather, if the 150,000 or so members of the A.M.A. think that this year's assessment of $25 each to keep up the confusion is all there is to it, we fancy they are in for a jolt.

The idea of health insurance is not going to down, because it is a natural growth of the time, technology, standards and social organization—and we don't mean "socialism," which the A.M.A.'ers are so glib at rolling on their tongues. It is the growth of understanding, at long last, that health is a natural endowment and right.

And the idea is not going to be downed by the most eloquent expositions of voluntary health insurance schemes. The latter are all very well, and every sensible person we know is paying for hospitalization and usually surgical benefits. But they are of only partial help against the disaster of chronic illness, disabling intervention of accident or infection or any of those visitations of physical misfortune that millions of American families know to their tragic cost. Granted that the plan now in Congress involves too radical and traumatic a wrench to medical services as they have developed in our society, the principle of protection against catastrophe is indestructible. Certainly it is firm against twenty-five bucks in the kitty and nation-wide broadcasts on the subject of "State Socialism."

Louisville *Courier-Journal.*

EXPEDIENTS IN DOCTOR SHORTAGE

Once again Indiana and the nation face the prospect of home-front doctor shortage. Wartime conditions impose a heavy drain on medical manpower. There is no more of an all-around satisfactory answer to this than there is to the other enormous problems posed by war.

In Indiana, however, the State Medical Association in setting up a procurement committee such as it had in World War II. In co-operation with the armed forces, this committee will seek to provide doctors from areas where medical services will not be too severely curtailed by their absence.

Another step which should be taken immediately is the passage by Congress of measures to force doctors trained at government expense in World War II to join the armed forces ahead of reservists with previous wartime service. This move is indorsed by the American Medical Association.

During World War II, 5,000 men received government training as physicians, some of them four years of it, but saw little or no active service. After the war ended they were released from any legal obligation to serve. They weren't needed then, but they are badly needed now.

It is only fair that doctors who not only were spared military service in World War II but who received free medical educations should now enter the armed forces ahead of older reservists. Yet at least 734 reserve medical officers have been called by the Army. Most of these men already have made extensive sacrifices for their country.

While there is no really satisfactory solution to wartime doctor shortages, the Indiana procurement program and the "draft" of government-trained personnel are expedients which will help to soften the blow and assure fairness all around.

—*Indianapolis Star*

DIABETES DETECTION DRIVE

DURING the week of November 12 to 18, 1950, the physicians of Indiana, as well as those of other states, have an opportunity to participate in the nation-wide Diabetes Detection Drive. It is essentially the physican's function and duty to discover the hidden diabetic, just as it is his task to supervise the treatment of those whose diabetes has been diagnosed. Therefore, it is better that we as physicians maintain the initiative and keep this type of preventive medicine in the hands of the medical profession, rather than leave it to be grasped by the ever-lengthening tentacles of governmental agencies. It is of prime importance that any large-scale diabetes detection program be placed firmly in the hands of the medical profession, working through organized medical societies.

The Diabetes Detection Drive week has these important aims:

1. To screen everyone in the community for diabetes.
2. To make sure that every person having a positive urine test for sugar see his physician for a blood sugar determination.
3. To instill in the community an awareness of diabetes and to inform the population of the problem existing relative to the number of hidden diabetics in their midst.
4. To extend the knowledge of diabetes among diabetics and to improve the methods of handling it.

The cooperation of every practitioner in the state is vital to the success of the Diabetes Detection Drive. This should not be difficult, since the physicians know well the seriousness of the problem of diabetes.

It is a well-known fact that, in addition to the approximately one million known diabetics now under treatment, pilot surveys indicate that perhaps as many as two million more may be potential diabetics. Last year our own Diabetes Detection Drive led to the examination of 41,684 urine specimens, of which 680 were from previously undiscovered diabetics.

Every physician should be familiar with the fact that this program, so important from the view of both the medical profession and the public, is designed to further the detection of the disease in the general population and at the same time to disseminate information for the improvement of the condition of known diabetics.

It is certain that physicians, once cognizant of these facts, will co-operate, as they have so well in the past two years, to make this approaching Diabetes Detection Drive the most successful one of all.

Marshall I. Hewitt, M.D., Chairman,
Committee on Diabetes

1. Dr. Alfred Ellison, incoming president, receiving the gavel from Dr. C. S. Black, retiring president.
2. Dr. Alfred Ellison, South Bend, president-elect, Mrs. C. S. Black, Mrs. Ellison, and Dr. C. S. Black, Warren, president.
3. Left to right: Dr. C. S. Black, Warren, president; Dr. George F. Lull, secretary and general manager of the A.M.A.; Dr. J. William Wright, Indianapolis, president-elect 1950-51; Dr. J. W. Strange, Loogootee, General Practitioner of the Year; Thomas A. Hendricks, secretary, Council on Medical Service, A.M.A., and executive secretary emeritus I.S.M.A.
4. Left to right: Dr. Roy V. Myers, Indianapolis, treasurer; Dr. W. U. Kennedy, New Castle, chairman of the Council; Dr. A. P. Hauss, New Albany, past president; Dr. Alfred Ellison, South Bend, president-elect; Dr. Elmer L. Henderson, Louisville, president of the A.M.A.
5. Left to right: Mr. Fred Thomas, Greenfield, president, Indiana Pharmaceutical Assn.; Dr. W. M. Cockrum, Evansville, co-chairman Committee on Convention Arrangements; Dr. W. L. Porttens, Franklin, chairman, Executive Committee; Dr. R. M. S. Barrett, St. Louis, speaker; Dr. George V. Daniels, Marion, past president; Mrs. D. E. Lybrook, Galveston, president Woman's Auxiliary.

CONVENTION NOTES

Dr. Andy Hall, National GP of 1949, proved to be an interesting, vigorous and inspiring speaker. His story about an exchange of letters with the Federal Security Agency was the best. He received two letters, the second of which complained that he had not answered the first one, which original letter had invited him to travel to Washington to discuss what might be done to alleviate the so-called staggering problem of the aged. His answer to the second letter, among other things, suggested that an adoption of a socialized medicine scheme such as is in vogue in Russia would lower the length of life in the U. S. from 68 to something like 48, and that this would automatically lessen the number of aged and also their problems. Dr. Hall is now complaining that his letter has not been answered by Mr. Ewing.

* * *

Meetings of the House of Delegates were characterized by the smooth presiding of President Black, and by the attendance of numerous members of the Association as observers. Reference Committees reported active interest by many members on some of the resolutions which were controversial.

* * *

Not a little sentiment was noted among the membership for the return of the Section Meetings. One of the resolutions introduced to the House of Delegates was a petition for the resumption of meetings of one particular section. This is a matter that might well be discussed by those who are for or against it with their councilors and delegates.

* * *

Military medical service was a popular topic for informal discussion throughout the convention. Several meetings were held by the committees concerned, and what little information as was available was dispensed. Many items cannot be settled now, pending the President's proclamation on the draft law, but the committees did benefit by the discussion, and were able to lay the groundwork for a plan of action on their part which will provide the armed services with physicians on an equitable basis, and will, at the same time, provide protection for the doctors in general.

* * *

The customary convention greetings received the modern "let's not waste any time and forthwith get down to business" treatment from Dr. C. E. Boyd of West Baden Springs. Dr. Boyd was co-chairman of the Committee on Convention Arrangements. His welcoming speech at the opening of the General Meeting on Tuesday morning consisted of "We're mighty glad to see so many of you fellows here for the meeting, hope you have an enjoyable time," or words of about that number and to that effect.

* * *

If at some leisure hour this winter you hear a moaning in the chimney, or feel an eerie tug at your sleeve, pay not too much attention. It will be merely the ghost of a second to some motion which Doctor Black was unable to recognize.

* * *

No doubt the first meeting of the House of Delegates at the 1950 convention of the I.S.M.A. will go down in history as one of the snappiest on record. It was snappy, all right, about 50° F. The delegates were so cold nothing short of chloroform could have put them to sleep. However, Doctor Black's warmth of personality saved the day.

DR. J. WILLIAM WRIGHT, SR.

PRESIDENT-ELECT

DR. J. WILLIAM WRIGHT of Indianapolis was chosen unanimously as president-elect of the Indiana State Medical Association at the annual convention in French Lick, on September 27.

Doctor Wright is past president of the Indianapolis Medical Society. He was a member of the Council of the Indianapolis Medical Society for three years, and was its chairman in 1944. In addition to having served faithfully as member or chairman of many committees of his county society, Doctor Wright has been co-chairman of the Legislative Committee of the state association since 1939.

After living for seven years in Canada, where he was born in 1887, in Chatsworth, Ontario, Doctor Wright moved to Indianapolis with his parents in 1894. He obtained his elementary and secondary schooling here and entered Indiana University School of Medicine in 1907. He was graduated with the M.D. degree in 1911.

He served a rotating internship in the Methodist Hospital in Indianapolis, and then entered into training for the specialty of otorhinolaryngology. He was associated with Dr. LaFayette Page until 1917, when he established his own office, with practice limited to diseases of the ear, nose and throat.

He is a member of the Indiana Academy of Ophthalmology and Otolaryngology, the American Academy of Ophthalmology and Otolaryngology, the Tri-ological Society, and is a Fellow of the American College of Surgeons.

POSTGRADUATE EDUCATION BY TELEPHONE

FOR THE first time in Indiana, and possibly for the first time anywhere, a medical postgraduate course was transmitted to its listeners by telephone.

On October 3 a panel discussion was originated at the Indiana University Medical Center in Indianapolis, transmitted over a leased telephone wire, and amplified for a large audience consisting of the Medical Staff Society of St. Elizabeth Hospital in LaFayette.

A panel composed of Dr. Lyman T. Meiks as moderator, and Drs. Stanley Battersby, Byron Rust, and William Norman as members, conducted an informal discussion on "Problems Relating to Children Arising in the Practice of Medicine."

A survey of the comments and criticisms offered by the audience shows that the reception was clear. The interest of the listeners was sustained throughout the presentation.

Constructive suggestions included that of providing some type of visual aids for the program. The possibility of providing for two-way communication and a question-and-answer period was presented.

The program was conducted on an experimental basis. Future presentations are being arranged, and each county society will be given the opportunity of participating. The next program is scheduled for November 7, at 8:00 p.m.

ONE HUNDRED AND FIRST ANNUAL SESSION

THE One Hundred and First Annual Session of the Indiana State Medical Association convened at French Lick on September 25, 26 and 27, 1950. A capacity attendance was registered, with 838 members, and a grand total of 1,610, including guests. This figure is almost identical with that of the 1947 session at French Lick.

The meeting was characterized by a splendid scientific program presented by our own members and by invited essayists from other states.

The House of Delegates voted down a proposal that Blue Shield issue a service type certificate in addition to its present indemnity contract. The directors of the company had sent up a trial balloon by mailing arguments for and against the service plan to all physicians several weeks before the meeting. Sentiment was strongly against the proposition, and the delegates voted it down without accepting the recommendation of the Committee on Prepaid Medical and Hospital Insurance that action be deferred until further study.

Three changes were made in the by-laws of the association. One requires that members be citizens of the United States or that they have taken out their first papers. A second gives the Council power to remit state dues of a physician if and when his county society secretary recommends that this be done. The third made the Committee on Rural Health a standing committee.

The delegates adopted a resolution asking members of the next Indiana General Assembly to appropriate sufficient funds to enable Indiana University School of Medicine to enlarge its facilities and thereby train more physicians.

The delegates recommended that the president appoint a new committee to implement the provisions of the Hess report.

A resolution was adopted which suggests a change in the law on premarital blood testing. Instead of mailing the specimens of applicants for marriage licenses, as the present law provides as a deterrent to hasty marriages, the delegates favored discontinuance of mailing specimens and establishing a waiting period between the time of applying for and issuing of a marriage license at the county clerks' offices.

A resolution asking that the medical districts be made to conform to the congressional districts was disapproved because the 1950 Indiana General Assembly is expected to revise Indiana congressional districts.

The report of a special committee on the Council which investigated the feasibility of screening disability insurance policies, approving those which came up to certain standards, and recommending them to the members of the association, was approved.

The delegates continued the A.M.A. Campaign Coordinating Committee and left the state dues at $35.00 to provide the committee with sufficient funds to continue its educational campaign against compulsory health insurance.

Officers elected were:

President-elect—J. William Wright, Indianapolis.

Treasurer—Roy V. Myers, Indianapolis.

Assistant treasurer—John M. Whitehead, Indianapolis.

Delegates to A.M.A.—H. G. Hamer, Indianapolis, and A. S. Giordano, South Bend; Alternates—Karl R. Ruddell, Indianapolis, and E. S. Jones, Hammond.

Indianapolis was selected as the 1952 convention city. (Indianapolis had previously been chosen for the 1951 meeting.)

The Council re-elected Frank B. Ramsey, Indianapolis, as Editor of THE JOURNAL, and A. W. Cavins, Terre Haute, as Associate Editor of THE JOURNAL. New Editorial Board members elected were Thomas M. Conley, Kokomo, and Clyde G. Culbertson, Indianapolis.

GOLF TOURNAMENT

One hundred and five members teed off on Monday morning to play the famous Hill Course for the Association Championship. First low gross honors were accumulated by Dr. W. D. Ritchie of Evansville. Second and third gross scores were made by Dr. K. T. Knode, of South Bend, and Dr. P. G. Lindenborg, of Indianapolis. First low net score was reported by Dr. J. E. Ball, of Indianapolis, followed by Dr. Howard Williams of Indianapolis, and Dr. William Thompson, of Winamac.

TRAP AND SKEET SHOOT

The following scores were registered at the annual Trap and Skeet Shoot:

Trap Shoot—100 Birds

No. 1.	Dr. C. M. Donahue, Carmel	97
2.	Dr. C. A. Laubscher, Evansville	92
3.	Dr. W. D. Challman, Mt. Vernon	89

Trap Handicap—50 Birds

No. 1.	Dr. C. A. Laubscher, Evansville	45
2.	Dr. Byron Nixon, Farmland	43
3.	Dr. H. K. Engleman, Georgetown	41

Skeet—100 Birds

No. 1.	Dr. C. A. Laubscher, Evansville	96
(tie)	Dr. F. P. Williams, Huntingburg	96
2.	Dr. J. R. Logan, Evansville	89
3.	Dr. George Wagoner, Delphi	88

Women—Skeet—50 Birds

No. 1.	Mrs. Barbara Crawford, Evansville	49
2.	Mrs. C. A. Laubscher, Evansville	48
3.	Mrs. Dan Tweedall, Evansville	23

Women—Trap—100 Birds

No. 1.	Mrs. Max Salb, Indianapolis	66

THE RESPONSIBILITY OF THE HOSPITAL FOR THE EDUCATIONAL STIMULATION OF THE GENERAL PRACTITIONER

SISTER LYDIA*

INDIANAPOLIS

HE SPECIALIST has been defined as a doctor who knows more and more about less and less; conversely then, one might define the general practitioner as one who knows less and less about more and more! However, hospital authorities today are convinced that the general practitioner must know more and more about more and more. It is, then, necessary for us to examine our educational programs to determine whether we are giving the general practitioner the opportunity to acquire that broad knowledge and experience necessary to fulfill his role adequately as family doctor.

In the past thirty years hospital governing boards have become "education conscious" and "standards conscious" in consequence of the program of hospital standardization and medical staff organization, initiated and guided by the American College of Surgeons, and the approving of educational programs in specialties by the Council on Medical Education and Hospitals of the American Medical Association. These programs have emphasized medical education almost entirely on a specialty basis. Formerly hospital privileges were not considered essential to the family doctor for the reason that his practice was carried on largely in the home.

Through the foregoing thirty years, and even before, the hospital had recognized that it must undertake responsibilities in addition to the nursing of the sick. To perpetuate its services in the field of nursing it must accept the responsibility of teaching. Hence, it was universally accepted that the function of the hospital was at least twofold: embracing the care of the sick, and educating hospital personnel. The demand for postgraduate training in hospitals for the benefit of physicians seeking the approval of specialty boards made it essential for hospitals to *cooperate* with the medical staff in the organization and establishment of educational programs for the benefit of interns and residents, that they might qualify for board approval and/or fellowship in their specialty organization. Further, recognizing that such a project ensured better patient care and raised the level of the practice of medicine in all specialty fields, hospital governing boards *encouraged* the medical staff to initiate and carry out educational programs. Hence, the hospital has been an essential contributing factor in providing suitable educational facilities for those who wished to qualify for the approval of their specialty board.

Today the hospital is face to face with a project of even greater scope and magnitude, that of making room in its highly organized and highly specialized medical staff for the general practitioner. Members of the medical profession, as well as members of hospital governing boards and hospital administrators, are in whole-hearted agreement that there should be a place for the nonspecialist on the hospital medical staff. This proposal of the medical profession that the general physician work side by side with the specialist reverses the attitude of the past. The change cannot take place overnight; it requires the consideration, the interpretation, and the prudent but unprejudiced action by the medical staff through its credentials committee, its professional standards committee and its executive committee, and it brings new problems to the governing board of the hospital.

When the American Medical Association, in 1946, passed a resolution encouraging hospitals to include a section of general practice in their medical staff organization, and the American College of Surgeons incorporated the suggestion in its by-laws for hospital medical staffs, hospital governing boards wondered how this could be done without breaking down the safeguards which they had struggled to establish. So much stress had previously been placed on postgraduate training, so much seemed to depend upon specialty board approval, and/or fellowship in certain organizations, that this new recommendation seemed to be the very antithesis of all established policies regulating appointment to hospital privileges.

Twenty years have effected as much change in the conformation of the medical staffs of hospitals and the now universal use of hospital facilities by the public, as were effected in the little village in the Catskills while Rip Van Winkle took his twenty year siesta. We have only to glance at statistics to note that the people of today are infinitely more hospital conscious than they were two or three decades ago. In the last twenty years births in hospitals have increased from 621,896 to 2,820,791, more than 450 percent. Hospital ad-

* Administrator, St. Vincent's Hospital, Indianapolis.

missions of all classes of patients have almost tripled in this interval. Some of the factors influencing this increase in hospitalization of the sick are Blue Cross and other insurance plans giving hospital service benefits, and advances in science; the diagnosis and treatment of the sick frequently necessitates the use of facilities found only in hospitals.

Transferring the care of the sick from home to the hospital means that the family physician must have hospital medical staff privileges. It is not necessary that a specialist attend every delivery, neither is this true in the other fields of medical practice. Access to the hospital for the family physician is one of the most important and urgent problems of the day. The Council on Medical Education and Hospitals has recently said, "It was never intended that staff appointments in hospitals generally, or even in hospitals approved for residencies, should be limited to board-certified physicians as is now the policy in some hospitals. Such policies are detrimental to the health of the people and therefore to American medicine. Hospital staff appointments should depend upon the qualifications of physicians to render proper care to hospitalized patients, as judged by the professional staff of the hospital, and not on certification or special society memberships. In this opinion, the Council has the full concurrence of the Advisory Board for Medical Specialties." The Joint Committee for Coordination of Medical Activities has stated that there is an immediate need for integration of general practitioners into hospital staffs. Graham Davis, then president of the American Hospital Association, declared, "I think it would be the policy of the American Hospital Association to say that every reputable physician should have a hospital appointment." Dr. Wingate M. Johnson of Winston-Salem, North Carolina, states that "The public is demanding the general practitioner." Qualifications for appointment to hospital medical staffs have been based largely on advanced training. Now that the demand has come for the family doctor to be given staff rights, no one is in favor of lowering the standards. The alternative is to raise the qualifications of the general practitioner.

This issue is twofold, embracing the general practitioner already in practice, and embracing the general practitioner of tomorrow, he who is the medical student or the intern of today. By fulfilling its function of education, the hospital should be able to handle both phases of this problem in its relation to hospital service.

Assuming that the medical staff of St. Vincent's Hospital, Indianapolis, gives a representative estimate of the qualifications of the general physician, I shall quote statistics compiled from this staff membership. Of the total staff of 537 physicians, 232, or 43 percent, are classified as general practitioners, and 305, or 56 percent, under the specialty fields. Of the 232 general practitioners, 88, or 38 percent, have completed one or more years of residency training, aggregating a total of 150 years of residency training. These statistics for the nonspecialist are in striking contrast to the specialty groups. Of the 305 specialists, 250, or 82 percent, have completed one or more years of residency training, totaling 648 years of residency training. Considering that 232 general practitioners represent 150 years of residency training, in comparison to 648 years of residency training among 305 specialists, and with more than 40 percent of the staff represented in the field of general practice, it is, undoubtedly, our responsibility to consider the preparation of physicians for the field of general practice, and the establishment of an educational program adapted to their needs. There are those who will propose that, in time, specialization will grow to such an extent that all staff members will be specialists. Certainly specialization will continue to develop, but it *can never*, and should never supplant the general practitioner. There is a definite need for both the general practitioner and the specialist working in close cooperation and harmony. The specialist needs the general practitioner just as much as the general practitioner needs the specialist, and the patient needs both. More and more people express the need for a physician whose training uniquely qualifies him to treat the "whole patient" as well as to serve as the "family doctor." It has been rather surprising in my experience to note that the great majority of requests coming to me to recommend a physician specify that the physician qualify as a family doctor.

With the universal recognition of the vital need for good general practitioners of medicine, there must be brought about a renaissance of the family doctor. Dr. Karl Meyer, Medical Superintendent of Cook County Institutions, asserts "Unless medical schools and hospitals begin at once to train graduates of medicine for family practice, some other agency will force this issue to the embarrassment of organized medicine. An internship that will develop good family physicians must be long enough to give good working knowledge of all the specialties and at the same time help them decide where and when the service of a specialist is needed. Family practice need not become just a clearing house for patients, as the majority of ills can be handled by a graduate of an approved medical school who has served a good rotating internship of preferably not less than 18 months." Where attention has been given to the educational needs of the general practitioner, and where teaching programs have been established, as at Bowman Gray School of Medicine, Winston-Salem, North Carolina, to fit the graduate for his role as family doctor, two-thirds of the graduates have expressed their preference for general practice. These young doctors have been influenced by the teaching program which places emphasis on consideration of the whole man. Family doctors

are assigned as members of the teaching staff, and every effort is made to have the student learn the art, as well as the science of medicine. Cases selected for presentation are typical of those seen in general practice. Some cases are purely functional, and some organic, while some are mixed. The importance of the history and the physical examination is emphasized, and graduates are allowed to spend at least six months' preceptorship under a family physician, before commencing the internship in the hospital.

At the University of Minnesota advances have been made in the development of an educational program for the general practitioner. Dr. Myron Weaver, Dean of the School of Medicine, is of the opinion that we must provide an internship that offers special training for general practice, beginning with a full year of internship of medicine and the medical specialties, followed by a second year of internship of obstetrics, pediatrics, and some aspects of surgery. General physicians share with the specialists the appointments on the teaching staff and it is distinctly advantageous to the intern to receive two full years of hospital experience.

The University of Michigan has also established a two year educational program in the form of a two year residency for general practitioners. A third year is optional. For a number of years, members of the faculty had noted that very few of their graduates planned to go into general practice. Undoubtedly they would go into general practice if, for economic reasons, they were not able to continue their residency training program, but the important fact was that no one was starting out with the idea that he would end up in general practice.

After interviewing the seniors it was learned that the reason some of them did not intend to go into general practice was that they felt there was no program where the educational level was equal to that of the medical school from which they were graduating, or equal to that of the training programs that were established for the specialties. As the program is now established at the University of Michigan and its affiliated hospitals, it is still in the experimental stage, and its success is still to be determined. In these programs emphasis is placed on the conditions that can be diagnosed and treated by the general practitioner, at the same time not omitting the diagnostic points of unusual conditions that serve to inform the general physician that *here* is a case which requires special technic either in diagnosis or therapy and because of this should be referred to a physician who has been trained in a particular field of medicine.

The American Academy of General Practice is stressing two years of hospital training as a desirable minimum in preparation for general practice, this internship to emphasize training in diagnosis and treatment in medicine, pediatrics, obstetrics, and surgery. The Academy even looks with favor on an additional year, totaling three years, as a possible future minimum of training. This group realizes that if general practitioners are to receive proper recognition in medical practice they must initiate and maintain high standards in their field of medical practice. Facilities must be made available for graduate training, and opportunities to train within our hospitals, that the necessary standards may be achieved.

In making appointments to the teaching staff of the hospital's educational program members of the nonspecialist group should be included, as well as members of the specialist groups. Medical specialties taught only from the viewpoint of the specialist are not adequate instruction for the general physician. It is uniquely the role of the general physician to emphasize the patient as an individual, rather than an interesting disease in an individual. He is able to introduce and work into clinical discussions an evaluation of the patient's situation, his economic and his personal problems, as they affect his present condition, and will influence his after care. The general practitioner is well suited, because of the broad scope of his medical activities, to guide the house staff in the subjects of medicine as an art, in medical ethics, medical economics, and community health facilities.

Finally, there is a new feature of training, perhaps not too common today, especially in relation to the hospital training program, which I feel will eventually become an essential factor and a requisite of the general practice internship and residency: that of making house calls, either as a part of his outpatient service, if the hospital has a clinic for the indigent, or under the supervision of selected general practitioners to whom he is assigned for this purpose. This practical experience gives the intern or resident first-hand examples, and serves as an object lesson for the fulfillment of his future role as family doctor.

An educational program for the general practitioner is an obligation of every hospital. We know that the program as set up today for the house staff is inadequate for the advancement of the general practitioner. Hospitals having sufficient qualified general physicians available for staff appointment should, at once, encourage the establishment of a department of general practice, as a part of the medical staff organization. The members of this department with teaching ability should be encouraged to participate in departmental meetings and in the teaching activities of the staff. In cooperation with the Council on Medical Education and Hospitals of the American Medical Association, a worth-while opportunity presents itself for hospitals to experiment with the length and content of the educational programs for interns and residents in general practice. Hospital and medical associations in their local, state and national meetings have opportunity to include this subject for study and discussion on

their programs, and in this way the entire group will profit by the experiences of the few programs already active. Without doubt, such an educational project is a responsibility of the hospital, but only the interest and the cooperation of the medical staff will ever achieve its successful operation.

If in the past thirty years educational programs in hospitals have stimulated the interest of the specialist, thereby achieving his training and professional prestige, certainly today hospital authorities should not hesitate to accept this new challenge, the educational stimulation of the nonspecialist, that he, too, may occupy his rightful and proper place on the hospital medical staff.

The hospital has the obligation to stimulate the educational program for the nonspecialist as well as the specialist, but the teaching assignments, the activities, and the promotion of any educational program for doctors, are the responsibility of the medical staff; a responsibility shared by the specialist and nonspecialist alike, to insure instruction and training of sufficient scope, and to fulfill adequately the requirements for the practice of either general or specialized medicine.

Deaths

Marcus Ravdin, M.D., of Evansville, died suddenly on September 12. He was eighty-four years old, and had practiced in Evansville for fifty years. He was a graduate of the Memphis Hospital Medical College, in Tennessee, in 1900. Doctor Ravdin was an honorary member of the Vanderburgh County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Elmer D. Wright, M.D., of Seymour, died on September 25, at the age of seventy-one. He was a graduate of the Physio-Medical College of Indiana, in Indianapolis, in 1900, and had practiced in Seymour for fifty years. He was a member of the Jackson County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Abram L. Cabell, M.D., of Terre Haute, died on October 6, at Culver. He was eighty-four years old. He was a graduate of the Howard University College of Medicine, Washington, D.C., in 1895, and had practiced in Terre Haute for more than fifty years. Doctor Cabell was an honorary member of the Vigo County Medical Society and the Indiana State Medical Association, and a member of the American Medical Association.

John Perry Retts, M.D., died at his home in Martinsville, on September 27, after a short illness. He was eighty years old, and had retired from practice. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1901.

Albert W. Miller, M.D., of Indianapolis, died on September 12, at the age of seventy-one. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1903, and practiced in Ripley County before going to Indianapolis, where he practiced for forty years. Doctor Miller was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

Clark W. Day, M.D., died suddenly on September 23, at the age of seventy-four. A graduate of the Physio-Medical College of Indiana, in Indianapolis, in 1901, he had practiced in Indianapolis for forty-nine years. Doctor Day was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Edgar A. Doan, M.D., of South Bend, died on September 1, at the age of seventy-eight. He was a graduate of the Medical Faculty of Trinity University in Toronto, in 1896, and had practiced in Mishawaka for many years, until he retired and moved to South Bend.

Douglas A. Leathers, M.D., of Indianapolis, died on October 1 after a long illness. He was ninety-one years of age. He was a graduate of the Jefferson Medical College of Philadelphia in 1886, and practiced in Mooresville until 1890, when he moved to Indianapolis, where he practiced for approximately sixty years.

News Notes

CENTRAL STATES SOCIETY OF INDUSTRIAL MEDICINE AND SURGERY

The annual Fall meeting of Central States Society of Industrial Medicine and Surgery will be held in Indianapolis Thursday, November 9, 1950. A varied program is to be presented, as follows:

The forenoon session is to be in Indianapolis General Hospital.

8:00 A.M. Registration of Society members and wives at Indianapolis General Hospital.

8:00-10:00 A.M. Visiting Surgery and Out-Patient Clinics.

10:15 A.M. Address of welcome by Hon. Al Feeney, Mayor, followed by Conference and Case Presentations, Dr. Allan K. Harcourt, presiding. Dr. Burleigh Matthew, "Eye Medications and Instruments."

12:15 P.M. Luncheon for doctors—Indianapolis General Hospital Cafeteria.

12:15 P.M. Board of Governors of Central States Society of Industrial Medicine and Surgery—Indianapolis General Hospital.

The afternoon session is to be held in Thurman B. Rice Auditorium, Indiana State Board of Health building, 1330 W. Michigan St.

2:00- 2:15 P.M. Business Meeting.

2:15 P.M. Address of welcome by Hon. Henry F. Schricker, Governor, followed by
"The Problems of Cardiovascular-Renal Disease in Industry"—by Dr. James D. Pierce.
"Recent Developments in Occupational Diseases in Indiana"—by Dr. Louis Spolyar.
Symposium on Medical Testimony:
From a doctor's standpoint—Dr. E. S. Jones.
From an attorney's standpoint—Attorney James V. Donadio.
Round Table Discussion—Questions and Answers.

5:30- 6:30 P.M. Social Hour—Athenaeum, Michigan and New Jersey Sts., followed by dinner for visiting guests.

8:15 P.M. Joint Meeting with Indianapolis Medical Society—Athenaeum Auditorium, with the following program:
"Low Back Pain"—Dr. Fremont Chandler, Chicago, President-elect American Orthopedic Association.
"Opportunities in Industrial Medical Practice"—Dr. Edward C. Holmblad, Managing Director, American Association of Industrial Physicians and Surgeons.

A program will be arranged for the doctors' wives. All doctors are cordially invited to attend this meeting. Dr. E. B. Lamb, of Indianapolis, is president of the society.

The Brayton Skin and Cancer Foundation will have two meetings during November. The first one, on November 16, will be presided over by Dr. Louis Brunsting, of the Department of Dermato-Syphilology of the Mayo Clinic. Doctor Brunsting will also address a seminar at the Indiana University School of Medicine, on November 17, at 8:00 p.m. The second meeting will be held on November 30, when Dr. Martin Van Studdiford, professor of Dermato-Syphilology of Tulane University, New Orleans, will preside. Both meetings will be held at Indianapolis General Hospital. Papers will be presented and case reports and a discussion of the cases will be held.

The Radiological Society of North America will hold its 36th annual meeting at the Palmer House in Chicago, December 10 through 15, 1950. Dr. Wendel G. Scott, of St. Louis, will present the annual Carmen Lecture. More than sixty papers, as well as refresher courses, will be featured on the program.

INTER-AMERICAN CONGRESS ON BRUCELLOSIS

The Third Inter-American Congress on Brucellosis will be held in Washington, D. C., November 6 to 10, for the purpose of reviewing advances in research on brucellosis that have been made since the last Congress was held in 1948. Dr. Wesley W. Spink, of the United States Committee on Brucellosis, is chairman of the Organization Committee.

PRIZE ESSAY CONTEST

The American Dermatological Association is offering a prize of three hundred dollars for the best essay submitted of original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. The purpose of this contest is to stimulate younger investigators to original work in these fields. Manuscripts typed in English, with double spacing as for publication, together with illustrations, charts and tables, are to be submitted in triplicate not later than February 1, 1951, and should be sent to Dr. Louis A. Brunsting, Secretary, American Dermatological Association, 102-110 Second Avenue, Southwest, Rochester, Minnesota.

A.M.A. CLEVELAND SESSION FOR GENERAL PRACTITIONERS

Plans for the A.M.A. Clinical Session to be held in Cleveland from December 5 to 8 indicate that it will be an outstanding meeting for postgraduate instruction and study. The program is being planned especially for general practitioners, and will be of interest to all doctors.

Clinical sessions will be conducted by outstanding teachers, and attendance at each session will be limited so as to allow time for and lend encouragement to discussions and questions about problem cases.

As in former years, many of the scientific exhibits will be correlated with clinical presentations. Cancer, pediatric problems, chest diseases and surgery will be managed in this manner.

Special demonstrations are planned on fractures, diabetes, rheumatism and arthritis.

Color television will again be featured. Surgical and medical clinics, originated at Western Reserve University, will be beamed direct to the convention hall, for viewing in full color.

Other attractions of the meeting include the House of Delegates, and the selection of the General Practitioner of the Year.

Hotel rooms will be scarce. Those who plan to attend the Cleveland session should make reservations early. Reservation and advance registration forms are published in *The Journal of the American Medical Association.*

DR. BAUER'S NEW BOOK NOW ON SALE

Dr. W. W. Bauer's new book, "Santa Claus, M. D.," which gives expert, clear answers to all health questions, is now on sale. It can be purchased at local book stores, through the publishers, the Bobbs-Merrill Company, 730 North Meridian Street, Indianapolis 7, Ind., or through the American Medical Association.

Dr. Bauer, who is director of the A.M.A. Bureau of Health Education, has done a fine job with a very controversial subject. In an easy and nontechnical way, he presents medical evidence to dispute claims by advocates of compulsory health insurance that Americans are in bad health, that they can't afford medical care and that there are not enough doctors.

The front cover of the book says: "Your health is the subject of hot controversy between those who support compulsory health insurance and the medical profession. You—the patient, the taxpayer, the voter—are being asked to choose between two programs designed to solve your health problems. In a readable and often amusing style this book states your doctor's side of the question. It gives you expert testimony you need to make a decision that vitally affects your welfare."

George F. Lull, M.D.,
Secretary's Letter, A.M.A.

AMA PUBLIC RELATIONS CONFERENCE

The Third Annual Medical Public Relations Conference is set for December 3 and 4 in Cleveland—just prior to the Clinical Session of the American Medical Association. It will concentrate on county society programs aimed at increasing community goodwill toward the medical profession.

In attendance at the two-day session will be some 300 chairmen of state and county medical society public relations committees, society executive secretaries and public relations directors, officers of the American Medical Association Woman's Auxiliary and key representatives of allied health organizations.

The program schedule calls for four work sessions, two noon sessions and an evening session. All activities will be at the Hotel Statler.

The opening work session on Sunday, December 3, will take up the important "groundwork for a successful public relations program." On the docket will be discussions on organizing public relations committees, financing the program, techniques for finding out what public relations work is needed, program planning and ways to build support among society members.

Work sessions on Monday, December 4, will include a timely summary of "county societies and the legislative scene," a series of brief reports on specific worthwhile county public relations activities, and an open forum period during which conferees will divide into three groups to swap ideas with representatives from similar-sized communities.

"DR. CHRISTIAN," RADIO'S BELOVED DOCTOR, AWARDED CERTIFICATE OF MERIT BY MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

The Medical Society of the District of Columbia has honored radio's beloved doctor, "Dr. Christian," by conferring upon him a certificate for meritorious service to medicine.

The society feels "Dr. Christian" has done a remarkable job in bringing to the attention of the public the best qualities of the physician and has impressed the public with the value of the close relationship that exists between the patient and the family doctor. The Medical Society of the District of Columbia has chosen "Dr. Christian" because it feels his portrayal of the average practitioner is an honest and dignified characterization.

Jean Hersholt accepted the certificate at the Annual Dinner of the Medical Society, Wednesday, October 4, in the Presidential Ballroom of the Statler Hotel, Washington, D.C.

Army SHORT 1,325 physicians NOW!
500 WW II Reservists to be affected!
570 Navy V-12s to serve with Army!
Army will need 3,200 physicians!
Nearly ALL in FIRST draft categories to be called!
Four GOOD reasons to volunteer NOW!

The Army currently has an immediate shortage of 1,325 physicians. These physicians must be provided very shortly if essential medical service is to be maintained. The following steps have been taken toward this objective: A limited number of World War II physicians are being called involuntarily from the Reserves. In addition to those called as individuals, Reserve medical officers assigned to Organized Reserve Corps units will be called to duty as their units are brought into active service. The professional complements of the larger medical units will not be called for initial training phases. Approximately 500 physicians with World War II service are affected by individual and unit recalls.

In addition, the Navy is making an initial recall of 570 V-12 physicians in the Naval Reserve who have not had previous active duty. These physicians will be detailed to the Army to meet current critical requirements. As soon as the Selective Service System starts meeting our requirements, Navy personnel will be returned to that service and involuntarily recalled Reserve officers will be released from duty except for those in the higher grades being utilized as specialists and in senior command assignments. Specialists cannot be released unless Public Law 779 provides replacements for them. Army requirements will be 3,200 physicians to meet current expansion plans.

From the foregoing, it is obvious that practically all physicians in category one under Public Law 779, as well as a sizeable proportion of category two, will be brought on active duty. There are certain specific advantages that will accrue to those who volunteer now rather than wait a few weeks for the draft. First, volunteers will receive an additional $100 per month professional pay. Second, those who volunteer and are commissioned need not register. Third, professional skills can be utilized better than under Selective Service, which makes only bulk numbers of physicians available without classification. Fourth, those who volunteer will have the satisfaction of knowing they are rendering service to their country at a time when international tensions are threatening a way of life which has made possible the development of a medical profession that embodies the highest principles and ideals of the Hippocratic oath.

Individuals can obtain information and necessary instructions for obtaining Reserve Commissions from the Office of the Unit Instructor, in the Military District in which they reside. Inquiries also may be directed to the Surgeon of the 5th Army, 1660 E. Hyde Park Blvd., Chicago 15, or the Surgeon General, Department of the Army, Washington 25, D.C.

A.M.A. INDICTS EWING

The American Medical Association, in a blistering indictment of Federal Security Administrator Oscar Ewing, which stated that he had twice been given a vote of "no confidence" in Congress, recently characterized him as "a disappointed, embittered bureaucrat, who should be removed from office before he does further harm to the country."

Dr. George F. Lull, general manager of the A.M.A., who issued the statement, declared:

"Mr. Ewing, in his speech yesterday before the American Jewish Congress, descended to the depths of political demagoguery when he falsely implied that the American Medical Association was practicing discrimination against Jews.

"He has long been a fomenter of class hatreds and he is now attempting to incite religious and racial hatreds in the manner of Hitler's Germany.

"Mr. Ewing is a case of arrested political development and his irrational statements undoubtedly are a consequence of thwarted ambitions and a growing persecution complex, but he is wholly unfit for public office.

"The two Houses of Congress, in successive years, have given Mr. Ewing a decisive vote of 'no confidence,' by rejecting his attempts to gain Cabinet stature and control over the medical profession through the creation of a Department of Health, Education and Security.

"President Truman should finish the job and dismiss Mr. Ewing from the public service before he does further harm to the country."

AMERICAN NURSES' ASSOCIATION FORMS COMMITTEE TO MEET CIVIL AND MILITARY NURSING NEEDS

To assure maximum preparedness of the nursing profession, the American Nurses' Association will appoint a Committee on Nursing Resources to Meet Civil and Military Nursing Needs, it was announced by Miss Ella Best, Executive Secretary of the ANA.

At the same time, Miss Best revealed that the ANA has called upon its member nurses' associations in the 48 states, Hawaii, and Puerto Rico to appoint similar committees to cooperate with civil and military defense authorities in meeting requirements for professional nursing service.

Functions of the ANA Committee on Nursing Resources to Meet Civil and Military Nursing Needs will include:

1. Securing cooperation of state and other nurses' organizations in meeting civil and military needs;
2. Developing criteria to assist nurses in determining their essentiality.

Posthumous award of the Purple Heart and the Silver Star Medal to **Captain Robert M. Moore, Jr.**, of Indianapolis, has been announced by United States 8th Army headquarters. Captain Moore was fatally wounded while serving with the medical detachment of the 24th Infantry Division artillery in Korea.

Dr. Harry McClelland, of New Castle, has moved to Millersburg, where he has established an office for the practice of general medicine and cardiology.

A native of Edinburg, **Dr. Don Manuel** has opened an office for the practice of medicine there. A graduate of the Louisville School of Medicine, he interned at the Chicago Presbyterian Hospital and spent two years with the U. S. Army, with the 97th General Hospital in Frankfort, Germany. Following his release from service, Doctor Manuel became associated in practice with the **Doctors Province**, in Franklin.

A native of Nappanee, **Dr. Lisle Roose** has returned there to become associated with **Dr. R. A. Fleetwood** in the general practice of medicine. Doctor Roose is a graduate of Northwestern School of Medicine, and served his internship and residency at the Chicago Maternity Center. He has been in general practice at Smithville, Ohio, for the past fifteen months.

Dr. C. Richard Yoder, who has been practicing in Bloomington, Illinois, has moved to Elkhart, where he will specialize in pediatrics. He is a graduate of the Ohio State University School of Medicine.

Dr. Robert D. Williams, who recently completed his intership at St. Vincent's Hospital in Indianapolis, is now in general practice at Markleville.

A 1939 graduate of Indiana University School of Medicine, **Dr. Gordon T. Herrmann** is now associated with **Dr. Herman M. Baker**, in Evansville. Doctor Herrmann spent his residency at the Medical Center, and served in the Army for approximately four years.

Recently discharged from the Navy, **Dr. George V. Teter** has gone to Boston for a thirteen months residency in pediatrics at the Children's Medical Center. He is a 1946 graduate of Indiana University School of Medicine, and plans to return to Indiana to establish a practice.

Dr. Ward Laramore, who has been in private practice in LaPorte, has returned to Billings VA Hospital on a full time basis.

Dr. A. G. Schlieker, formerly of East Chicago, and later of Spencer, is now located in Troy, Missouri.

Ray E. Smith, executive secretary of the Indiana State Medical Association, was a speaker at the Conference on M.D. Participation in Health Councils, which was held in Detroit on October 1. His subject was "The Inter-Professional Council."

Dr. James L. Doenges, of Anderson, was a speaker on the program at the annual meeting of the Association of American Physicians and Surgeons, which was held in Houston, Texas, on October 5, 6 and 7. His subject was "So You Think It Can't Happen Here." Indianapolis was selected as the site for the 1951 convention.

Dr. Jessie Elizabeth Jeffress, a graduate of the Woman's Medical College of Philadelphia, has opened an office for the practice of medicine in Gary.

A graduate of the University of Chicago School of Medicine, **Dr. Mary Elizabeth Davis Carroll** has established an office in Crown Point for the practice of medicine.

Announcement has been made of the association of **Dr. Robert L. Haller** with **Dr. N. L. Salon** in the general practice of medicine at 604 West Wayne Street, in Fort Wayne. A graduate of the Indiana University School of Medicine in 1945, Doctor Haller interned at St. Joseph's Hospital in Fort Wayne, and then spent two years in active military duty with the U. S. Medical Corps. Following his separation from service, Doctor Haller practiced for one year at Churubusco, before going to Fort Wayne.

Dr. Frederick L. Schoen, of Fort Wayne, has been called into military service, and is attached to Company B, 18th Infantry Battalion, USMC.

Opening of an office at 307 Strauss Building in Fort Wayne, for the practice of general and thoracic surgery, was announced recently by **Drs. John W. McCallister** and **James A. Lemons**. Doctor McCallister is a graduate of the University of Michigan School of Medicine, where he served as instructor in anatomy for one year. He served a forty-five months residency in surgery at Wesley Memorial Hospital, in Chicago, and spent two years with the U. S. Army. Doctor Lemons is a graduate of Northwestern University. He interned at Wesley Memorial Hospital in Chicago, and served his residency in general and thoracic surgery there, for a period of five years.

Dr. M. Joseph Barry, Jr., is now first assistant to the staff in psychiatry at the Mayo Clinic in Rochester. He recently completed his training at the Medical Center in Indianapolis.

Dr. Harry G. Nester has opened an office for the general practice of medicine at 720 Underwriters Building, in Indianapolis. He is a 1949 graduate of Indiana University School of Medicine, and a veteran of three years of military service.

INDUSTRIAL HEALTH TRAINING

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships which are being offered to qualified candidates who wish to pursue a graduate course of instruction which will qualify them for the practice of Industrial Medicine. Any registered physician, who is a graduate of a Class A medical school and who has completed satisfactorily two years of residency (including internship) may apply. During the first two years, the stipends for the Fellowships vary from $2,100 to $3,000. In the third year the candidate will be compensated for his service by the industry in which he is completing his training. Requests for additional information should be addressed to the Institute of Industrial Medicine, College of Medicine, Cincinnati 19, Ohio.

AMERICAN COLLEGE OF PHYSICIANS POSTGRADUATE COURSES

The American College of Physicians postgraduate courses are open to nonmembers with adequate preliminary training, as well as to ACP members. The fee is $60.00 to nonmembers.

Course No. 6. Peripheral Vascular Diseases, Including Hypertension. November 27 to December 2, Mayo Clinic and Mayo Foundation, Rochester, Minnesota.

Course No. 7. Gastroenterology. December 4 to 9, University of Pennsylvania Graduate School of Medicine, Philadelphia.

Course No. 8. Selected Aspects of Clinical Hematology. December 11 to 16, New England Center Hospital and Tufts College Medical School, Boston.

Course No. 9. Modern Trends In Diagnosis and Treatment of Heart Disease. January 22 to 27, 1951, Woman's Medical College of Pennsylvania and Other Philadelphia Institutions.

For further information, address E. R. Loveland, executive secretary, 4200 Pine Street, Philadelphia 4.

Dr. William G. Clevinger, who has been practicing in Kirkland for the past three years, has opened an office at 1610 N. Auburn Street in Speedway City. He is a 1944 graduate of Indiana University School of Medicine, and spent two years in service during World War II.

NEW AMA RADIO SERIES

The American Medical Association recently announced the release of a new series of electrically transcribed radio programs. The new series is number 25, and is entitled, "The Best Is Yet To Be." It deals with problems of the aging, and is considered to be the best radio production which the association has sponsored.

P. C. REILLY LABORATORY OF MYCOLOGY

The Brayton Skin and Cancer Foundation was host at a dinner on September 28 at the Indianapolis General Hospital to honor Mr. Peter C. Reilly for his financial assistance in the establishment of the Foundation's Laboratory of Mycology. Governor Henry F. Schricker officially designated the laboratory as the P. C. Reilly Laboratory, and presented it to the hospital. Dr. Francis E. Senear, Chairman of the Department of Dermatology of the University of Illinois, was present and spoke in commendation of the Foundation's work.

PUBLIC HEALTH SERVICE GRANTS

Among research grants approved recently by Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, were the following for Indiana:

Institution and Researcher	Amount	Subject
Harry G. Day, Indiana University, Bloomington	$5,983	Significance of lipoxidase in the metabolism of carotene and vitamin A.
Henry Moffler and P. A. Tetrault, Purdue Research Foundation, Lafayette	7,344	The biochemistry of Streptomyces Griseus and related antinomycete with emphasis on the mechanism of streptomycin formation.
Don E. Bloodgood, Purdue University, Lafayette	8,629	Sedimentation studies. Investigations on the fundamentals of suspended particles' behavior in sewage and water treatment.
M. G. Mellon, Purdue University, Lafayette	6,480	Spectrophotometric study of methods for determining low concentrations of ammonia, nitrate, nitrite, cyanide, and thiocyanate in water.
Dr. Ralph W. Phillips, Assistant Professor, School of Dentistry, Indiana University, Indianapolis	3,218	Studies on the relation of solubility to hardness of tooth enamel.

A.M.A. WASHINGTON OFFICE NEWS

WHO IS IN THE RESERVES SURGEONS GENERAL GIVE DEFINITIONS

Inquiries to the Washington Office of A.M.A. indicate uncertainty on the part of some physicians as to *Whether they actually are in the military reserves at this time,* and therefore subject to call.

Because of the many laws, rules and regulations involved, *only the proper military authorities can give a final answer in any particular case.* The best advice this office can give is this: If the man served in the *Army,* and has (or thinks he might possibly have had) a reserve commission, he should contact the commander of the military district in which he resides for official determination of his status. If he served in the *Navy,* and is concerned about his status, he should contact the commandant of his Naval district.

At our request, the Army Surgeon General's Office and the Bureau of Naval Personnel have supplied the following information, which should be considered only for guidance, *not for determination of status:*

ARMY:

"*Reserve* officer appointments or reappointments in force at the outbreak of World War II (or made subsequently) remain in force until six months after termination of the war or termination of the five-year appointment period, whichever is the later, unless specific action to terminate the appointment has been taken by the Department of the Army. Under current law in this instance, World War II has not been declared terminated."

NAVY:

"A man is still in the Naval *reserves* unless:

1. He has resigned his reserve commission, or
2. He has been discharged from the reserves.

The mere release to inactive duty of an officer in the Naval Reserves does not sever his connection with the Navy."

Air Force had no separate medical service during World War II. The Air Surgeon's office said that its situation would be covered by the above Army statement.

We repeat, *the proper course is for every man uncertain of his reserve status to contact his Military District commanding officer or Naval District commandant.*

NAVY ORDERED TO ASSIGN V-12 RESERVISTS TO ACTIVE DUTY WITH ARMY: ARMY TO RELEASE SOME OF WORLD WAR II RESERVES AFTER 3-4 MONTHS

Two developments have drastically changed the military medical situation. The net result is that *far fewer World War II reserves than anticipated will be called to active duty* in the next few months, and that many of those currently on active duty or yet to be called on mandatory orders *will be required to serve only three or four months, rather than twenty-one months.*

The most important development came in a directive from the new Secretary of Defense, General George C. Marshall. He ordered the *Navy* to call up enough of its V-12 reserves to meet the immediate requirements of *all three services,* with the first 235 to be on duty with the Army by October 15.

> *From now on, an Army spokesman said, the general policy will be to return veteran reservists to civilian life as fast as possible, with the hope that their active-duty tours will not exceed four months.* This will apply specifically to men called without their consent, but volunteers with World War II service will also be given consideration.

Army will not be able to apply its new policy uniformly to all reserve officers. Some members from at least two groups will not benefit from the plan:

1. Certain senior officer specialists in various categories, whose professional skills make them difficult to replace.
2. Certain senior command and staff officers whose military background makes them difficult to replace.

Navy has not indicated whether it will attempt to follow the Army's policy of reducing the service of World War II medical veterans. It already has a number of these men on duty, called up on mandatory orders before it started using its V-12 reserves. However, Navy officials have been concerned with the problem and would like to find some way of replacing veterans with non-veterans.

This help from Navy won't meet all Army's requirements during the next two or three months. While waiting for the doctor-draft to produce medical officers, *Army plans to call up a total of 500 reserves, mostly with World War II service.* However, 350 of them can look forward to returning to their practice after three or four months, or as soon as the draft makes replacements available.

Budget Bureau Cuts Hospital Authorization Fund in half. *Budget Bureau,* acting on order of President Truman to cut nondefense spending half a billion dollars, has sliced in half the fund Congress approved for Hill-Burton Act hospital construction. The reduction was from *$150,000,000* to *$75,000,000.*

This fund does not represent actual appropriations. It is an authorization, from which FSA may pledge federal assistance to states for hospital construction. Under this program the bills are paid from money appropriated as they come due. Action by Budget Bureau brings up again the same situation which threatened last spring when a House Committee reduced the hospital authorization to $75,000,000, a decision later reversed by House and Senate votes. *The difference is that now there is little chance of reversal of the decision.*

While U. S. will meet all hospital obligations for which it has made final and binding commitments, effects of the cut will be felt at state and local levels. A great deal of planning, fund-raising and bond-selling often takes place before the federal government is officially brought into the picture. *Consequently prospects are that some projects now in preliminary planning stages will have to be canceled out or deferred.* FSA officials advise that sponsors of hospitals which have not received final commitments from U. S. immediately get in touch with state hospital agencies to ascertain status of the particular projects.

U.S. Outlines Civil Defense Program; New Agency Is Proposed. A comprehensive plan of operations for civil defense has been prepared by National Security Resources Board for presentation to states and cities. At the same time, President Truman called on Congress to enact legislation to get the plan under way, including creation of a *Federal Civil Defense Administration,* with "power and authority to plan, review and coordinate the civil defense activities of the federal government and to coordinate the same with the civil defense activities of the states . . ."

It is the hope that states and cities will work out mutual assistance plans; if they don't, *the CD Administration would be empowered to require such assistance* in time of emergency. *It places full medical and other responsibilities on existing civilian agencies and individuals.*

If Congress does not create the new agency before recess, the overall plan will not be allowed to lie dormant. An NSRB spokesman said the President has sufficient executive funds to start the program without new appropriations, and sufficient authority to change NSRB from a *planning* to an *operating* agency. If it receives this power, NSRB could administer the program while awaiting creation of the new administration.

Whatever happens in Congress, there are strong indications that Mr. Truman will designate NSRB as the agency responsible for allocating physicians on a civilian-military basis. One proposal is to set up a Procurement and Assignment Service under Dr. Howard Rusk's Health Resources Advisory Committee within NSRB. This could work closely with Defense Department's Office of Medical Services, which already has control over the total numbers of medical officers the services may call up.

Here are medical highlights of the new defense program. *FSA* health personnel at *FSA* regional offices will staff federal civil defense central and regional offices at the outset, to be replaced by *PHS personnel.* Red Cross will have major responsibility for blood supplies, but transportation of blood within a state is the responsibility of the state. Maps showing 140 critical target areas have been prepared and will be sent to governors. *U. S. probably will purchase all regional medical stockpile supplies.* Minimum state and local obligations are spelled out in such activities as first aid and ambulance services, emergency hospital systems, casualty services, health supplies, laboratory services, sanitation services, medical services, morgue services, records, etc.

(The booklet outlining these plans, and including a copy of the bill for creation of a Civil Defense Agency, is entitled to United States Civil Defense. It is for sale at U. S. Government Printing Office, Washington, D.C., for 25 cents. In the near future other pamphlets will be published on the problems in various civil defense fields.)

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

(French Lick Session, 1950)

First Meeting

The first meeting of the Council was held in the Blue Room of the French Lick Springs Hotel at 11:15 a.m., Monday, September 25, 1950, with Dr. W. U. Kennedy, the chairman, presiding. Roll call showed the following present:

Councilors:

First District..... Herman T. Combs, Evansville
Paul D. Crimm, Evansville, alternate
Second District..... William C. Reed, Bloomington
Sam I. Rotman, Jasonville, alternate
Third District..... Parvin M. Davis, New Albany, alternate
Fourth District..... Not represented
Fifth District..... A. M. Mitchell, Terre Haute
V. Earle Wiseman, Greencastle, alternate
Sixth District..... W. U. Kennedy, New Castle
Seventh District..... Roy A. Geider, Indianapolis
Eighth District..... E. H. Clauser, Muncie
T. R. Hayes, Muncie, alternate
Ninth District..... Wemple Dodds, Crawfordsville
Tenth District..... W. H. Howard, Hammond
Eleventh District.... Elton R. Clarke, Kokomo
Twelfth District..... M. B. Catlett, Fort Wayne
Myron L. Habegger, Berne, alternate
Thirteenth District... Kenneth L. Olson, South Bend
G. O. Larson, LaPorte, alternate

Officers:

C. S. Black, Warren, president
Alfred Ellison, South Bend, president-elect
Roy V. Myers, Indianapolis, assistant treasurer
Frank B. Ramsey, Indianapolis, editor of THE JOURNAL
A. W. Cavins, Terre Haute, associate editor of THE JOURNAL

Members of Executive Committee:

C. J. Clark, Indianapolis
Albert Stump, Indianapolis, attorney
Ray E. Smith, Indianapolis, executive secretary
James A. Waggener, Indianapolis, field secretary

Convention Arrangements Committee:

William M. Cockrum, Evansville, co-chairman

Delegates and alternates to the A.M.A.:

A. S. Giordano, South Bend, delegate
Cleon A. Nafe, Indianapolis, alternate

On motion of Drs. Mitchell and Clarke, the minutes of the July 16, 1950, meeting of the Council, were approved as printed in the September, 1950, JOURNAL.

District meetings were reported scheduled as follows:

Seventh District_____October 18, 1950, Pittsboro
Eleventh District_____May 16, 1951, Peru
Thirteenth District_____November 8, 1950, Michigan City

UNFINISHED BUSINESS

1. *Convention arrangements.* Dr. William M. Cockrum, co-chairman, spoke briefly on arrangements that had been made for entertaining guests during the 1950 convention.

2. *Report of Special Committee on Disability Insurance.* Dr. Catlett, chairman, presented the following report, which, on motion of Drs. Howard and Clarke, was approved by the Council with the recommendation that it be adopted by the House of Delegates:

REPORT OF SPECIAL COMMITTEE ON DISABILITY INSURANCE

The Special Committee on Disability Insurance, which was appointed by the President upon the authorization of the Council, for the purpose of making a study of disability insurance to the end that standards might be established to which companies writing it might make their policies conform in order to obtain the approval of the State Medical Association, has had four meetings, and in preparation for those meetings has made a study of a number of policies recently and now being sold to physicians. We submit this as our report and recommendations in regard to the matter referred to us.

1. The State Medical Association should not select any one company and recommend that the physicians of the state buy the policy or policies offered by that company. There should be established a reasonable set of standards to which insurance policies should conform; and where policies are offered that conform to such standards the policies should receive the approval of the State Medical Association.

2. In order to make certain that policies offered by companies who seek the approval of the State Medical Association will adhere to the standards approved by the Association, a short form of agreement between the State Association and such companies should be made, to the effect that the companies will not change the forms of policies as designated by number, although this provision should not prevent companies from offering more than one form of policy for approval.

3. Any policy, to receive the approval of the State Medical Association, should comply with the following standards:

(a) All requirements set forth under Chapter 58, Section 1, page 173, of the Acts of 1947, Burns' 1949 Supplement, Section 39-4306, except those numbered B1, 16, 17, 18 and 19. Those required are mandatory.

(b) In addition to the requirements provided under (a), any policy to be approved should meet the following requirements:

(1) NON-CANCELLABLE. There shall be no provision for cancellation of the policy by the company.

(2) GUARANTEED RENEWABLE. There shall be a provision guaranteeing the insured's right to renew the policy for a specified number of years, and certainly to age 65, by the timely payment of premiums.

(3) FIXED PREMIUMS. The amount of the premium, or premiums, shall be stipulated in the policy, and there shall be no provision for assessment or other increased cost to the insured not stated in definite amount in the policy.

(4) INCONTESTABLE. It shall be provided, in substance that if the policy has been continuously in force two full years immediately preceding the beginning of a disability or the occurrence of a loss for which claim is made, the policy shall be incontestable as to the accuracy of the insured's statements contained in the application and as to the physical condition of the insured on the date of the application.

(5) NO DELAYED DISABILITY LIMIT. There shall be no provision evidencing directly or indirectly that the indemnity for total disability resulting from injury will not be payable if total disability does not result within a stipulated period of time following the accident.

(6) NO HOUSE CONFINEMENT. There shall be no provision requiring that the insured be house-confined during the whole or any part of any period of disability in order to be eligible for the maximum amount of indemnity stated for total disability.

(7) FULL INDEMNITY AS ACCRUED. There shall be no provision for accumulation to the end of the disability period of all or any part of the indemnity for loss of time. The policy shall provide that upon request of the Insured and subject to due proof of loss all of the accrued indemnity for loss of time on account of disability will be paid at the expiration of each thirty days (or four weeks) during the continuance of the period for which the company is liable.

(8) NO DISEASES EXCLUDED. The policy, if it purposes to indemnify for sickness, shall not exclude indemnity for any disease or sickness, nor shall it include any provision for reduced indemnity for certain diseases or sicknesses.

(9) ACCIDENT INSURING CLAUSE. The policy, in its insuring clause, shall embody coverage of loss resulting from accidental bodily injury, not bodily injury resulting from violent, external and/or accidental means.

(10) PHYSICIAN'S ATTENDANCE. The policy shall not provide that no indemnity shall begin to accrue until the first visit of a physician, nor shall it require visits of a specified frequency by a physician.

(11) TOTAL DISABILITY DEFINITION. Total disability shall be defined substantially as follows: Such disability as makes it impossible for the insured to perform the duties of his occupation.

(12) RENEWABLE TO AGE SIXTY-FIVE (65) AND FULL INDEMNITY REGARDLESS OF AGE AT TIME OF DISABILITY. The policy must provide that the coverage shall be renewable to age sixty-five (65). It may provide that after the assured reaches the age of sixty-five (65) it may be renewable at the option of the company. The policy must also provide that the assured shall be paid full benefits regardless of his age at time of disability.

(13) NON-AGGREGATE CLAUSE. The policy shall not contain a clause aggregating the indemnities paid for each disability. It shall contain a provision to the effect that when one claim is over, there remains to the benefit of the insured the full amount of protection afforded before any claim was made under the policy.

(14) WAITING PERIOD BETWEEN DISABILITIES BEFORE THE NEXT CLAIM IS CONSIDERED A NEW ONE. The policy shall contain a provision substantially as follows: If the insured, more than six months after the date of termination of a period of disability due to sickness, shall subsequently again become disabled from the same cause or causes, such subsequent period of disability shall be considered as a new period of disability and indemnity shall be paid in accordance with the proper provisions of this policy. If the insured, less than six months after the date of termination of a period of disability due to sickness, shall again become disabled from the same cause or causes, such subsequent period of disability shall be considered a continuation of the previous disability.

(15) PERIOD OF GRACE. The policy shall contain a provision to the effect that there exists an extension of time of thirty-one (31) days for the payment of premium beyond the due date, during which time the policy remains in full force and effect.

(16) WAIVER OF PREMIUM. The policy shall provide that after the insured has been disabled for a period of six (6) months or less any premium falling due thereafter during the disability will be waived.

(17) PARTIAL DISABILITY CLAUSE. Partial disability shall be defined substantially as follows: Partial Disability is such disability as prevents the insured from performing one or more important daily duties pertaining to his occupation.

Partial disability benefits must be paid regardless of whether or not the disability comes before or after total disability.

GENERAL STATEMENT

It is the recommendation of this Committee that any other provisions of policies not in conflict with the above and more attractive to physicians should be acceptable.

It is further recommended that this Committee, or a similarly constituted one, be continued for the purpose of conferring with insurance representatives and members of the medical profession with regard to additional provisions or any other problems which may arise in connection with this service the Committee has been requested to perform for the profession.

A proposed form of agreement between the Indiana State Medical Association and insurance companies whose policy meets with the approval of the Medical Association is attached.

Respectfully submitted,

M. B. CATLETT, M.D., *Chairman*
W. H. HOWARD, M.D.
KENNETH OLSON, M.D.
ELTON R. CLARKE, M.D.

AGREEMENT

(1) THIS AGREEMENT, made the ..... day of ....., 195.... by and between the INDIANA STATE MEDICAL ASSOCIATION, of Indianapolis, Indiana, hereinafter referred to as the Association, and ..... of ..... County of ....., State of ....., hereinafter referred to as the Company:

WITNESSETH, that

(2) In consideration of the approval hereby granted by the Association of certain policy forms and/or policy amendment forms submitted to the Association and hereinafter designated by form numbers, the Company agrees not to use any of said form numbers as a whole or part of the form number of any other policy or policy amendment, or of any changed, corrected or revised edition of a form so approved, unless same shall have been submitted to and approved by the Association.

(3) The Company further agrees that, upon the receipt of written notice from the Association of withdrawal of approval of any policy form and/or policy amendment form hereinafter designated, it promptly in turn will give written notice of the withdrawal of the Association's approval to all of its agents and/or other representatives having authority to negotiate policies of accident and/or health insurance in Indiana.

(4) The following form numbers designate the policy forms and/or policy amendment forms submitted to the Association and considered as coming within the scope of this agreement:

Policy Form Numbers—Policy Amendment Form Numbers

IN WITNESS WHEREOF, the parties to this agreement have subscribed their names the day, month and first year above written, in Indianapolis, Indiana.

INDIANA STATE MEDICAL ASSOCIATION

.....

By .....
(Executive Secretary)

By .....
Secretary

Following discussion by Drs. Olson and Clarke, it was taken by consent that the Council allow the Special Committee on Disability Insurance and the Special Committee on Income Pension Plan to work out any conflicts in the two plans and make satisfactory adjustments.

NEW BUSINESS

1. *Legislative matters.* Dr. J. William Wright, co-chairman of the Committee on Public Policy and Legislation, spoke on recent activities of the legislative committee and of plans for the future.

2. *Matters referred to Council by Executive Committee:*

a. *Resolution regarding increased enrollment in Indiana University School of Medicine.* Dr. Black read the following resolution, which was adopted by the Council and is to be referred to the House of Delegates, on motion of Drs. Mitchell and Geider:

WHEREAS the medical profession of Indiana is deeply aware of its responsibility to provide adequate medical care and assistance for the citizens of the State of Indiana, and

WHEREAS medical services in a number of communities, especially in the rural areas, would be improved if more physicians were available for the private practice of medicine, and

WHEREAS the Indiana University School of Medicine, the State's only medical school, is the principal source of physician supply for Indiana, and is now operating at its full capacity, and

WHEREAS, the Board of Trustees of Indiana University will again present plans for expanding and improving medical education facilities at the Indiana University School of Medicine at the next session of the Indiana General Assembly, *Now Therefore*

Be It Resolved, That the delegates of the Indiana State Medical Association do hereby urge the 87th General Assembly of the State of Indiana to appropriate necessary funds in order that the Indiana University School of Medicine may enlarge its facilities and add to its faculty so its enrollment can be increased sufficiently to meet more nearly the physician needs of the state;

That a copy of this resolution be forwarded to the members of the Budget Committee of the state of Indiana, and that each holdover Senator and each Senator and Representative elected to the 87th General Assembly on November 7, receive a copy of this resolution. Also, that a copy be sent to the members of the Committee on Medical Education and Hospitals of the American Medical Association.

3. *1951 dues of physicians in military service.* On motion of Drs. Mitchell and Geider, the Council voted to remit the dues of physicians in active military service in 1951, if requested by the county medical societies, and to recommend to the American Medical Association that the A.M.A. memberships of these physicians be continued while they are in active military service.

4. *Report of Committee on Medical and Nursing School Scholarships.* Dr. C. J. Clark, chairman, read from the minutes of the August 6, 1950, meeting of the committee, in which the committee asked the Council for the authority to set the amount to be awarded to each recipient of a nursing school scholarship, and also for authority to require each recipient to practice in Indiana for three years or for a period equal to the time she received funds from the scholarship, upon completion of her training. In the event she does not fulfill her contract, she shall be required to refund the money received through the scholarship. Dr. Geider put the above provisions in the form of a motion, which was duly seconded and carried.

5. *Election of* JOURNAL *editors.* On motion of Drs. Mitchell and Olson, Dr. Frank B. Ramsey, Indianapolis, was re-elected editor of THE JOURNAL for 1951, and Dr. A. W. Cavins, Terre Haute, was re-elected associate editor of THE JOURNAL for 1951.

6. *Election of Editorial Board members.* On motion of Drs. Howard and Catlett, Dr. Clyde G. Culbertson, Indianapolis, and Dr. Thomas G. Conley, Kokomo, were elected members of the Editorial Board to serve for three years, and to succeed Dr. J. T. Oliphant, Farmersburg, and Dr. Kenneth Kohlstaedt, Indianapolis.

7. *Report of Committee on Retirement Income Pension Plan.* Dr. Elton Clarke, chairman, submitted the following final report of the Special Committee on Income Pension Plan, which was to be presented to the House of Delegates:

FINAL REPORT OF SPECIAL COMMITTEE ON INCOME PENSION PLAN

At the meeting of the Council of the Indiana State Medical Association on September 26, 1949, Dr. Cyrus J. Clark of Indianapolis, Dr. Albert M. Mitchell of Terre Haute, and Dr. Elton R. Clarke of Kokomo, as chairman, were appointed as a committee, with the advice and counsel of Mr. Albert Stump, to study the retirement problem of the members of the association. The committee was further instructed to adopt a plan to effect a practical solution to our retirement problem.

After a meeting to establish the problem, each insurance company licensed to operate in the state of Indiana was invited to submit its solution to our problem. At a meeting in the State Medical Association offices in Indianapolis, more than 16 of the best known companies operating in the state of Indiana submitted their solutions and plans to solve our problem. After several meetings of the committee, its final report was submitted to the Council on July 16, 1950, for its action.

The report recommended the adoption of the plan known as the Independence Plan submitted and underwritten by the Jefferson National Life Insurance Company of Indianapolis, Indiana. This report was unanimously adopted by the Council at that time. Our committee is pleased to make this report stating the adoption of the Independence Plan, which will be of untold value and benefit to those members of our association who elect to take advantage of the plan for many years to come. The details of the Independence Plan will be explained to each member in the near future.

Respectfully submitted,

ELTON R. CLARKE, M.D., *Chairman*
ALBERT M. MITCHELL, M.D.
CYRUS J. CLARK, M.D.

8. *Report of Indiana Military Manpower Committee.* Dr. C. J. Clark, chairman, reported that so far the committee had not been called upon to take any action. He stated he felt "the committee should be a liaison committee, an appeal committee, from the standpoint of the county level."

9. *Report of Indiana A.M.A. Campaign Coordinating Committee.* Dr. Nafe, chairman, reported on the expenditures of his committee for the newspaper advertising campaign and recommended that the committee be continued next year "in keeping with the financial position of the association and in keeping with the political situation as it exists. For this reason, the committee is of the opinion that the Council probably should recommend that our dues for next year not be decreased."

Dr. Mitchell moved that Dr. Nafe's recommendations be carried to the House of Delegates. Motion seconded by Dr. Crimm, and passed.

10. *Collection of A.M.A. dues.* The executive secretary announced that as of September 23, 1950, total A.M.A. membership of Indiana physicians was 2,328.

On motion of Drs. Howard and Mitchell, the Council voted to bring to the attention of the House of Delegates the fact that not enough Indiana members are paying A.M.A. dues to insure the continuation of the present representation of four Indiana delegates in the A.M.A. House of Delegates.

11. *Advertising on cover page of* THE JOURNAL. On motion of Drs. Crimm and Howard, the Council disapproved the use of one-half of the cover page of THE JOURNAL for advertising.

Date for Midwinter Council Meeting

The Council set Sunday, January 14, 1951, as the date for the midwinter meeting.

Dr. Mitchell, chairman of the Committee on Conference of County Medical Society Officers, announced that that conference would be held on Sunday, January 28, 1951.

There being no further business, the Council adjourned at 2:00 P.M., to meet again on Wednesday, September 27, immediately following adjournment of the House of Delegates.

THE COUNCIL

(French Lick Session, 1950)

Second Meeting

The second meeting of the Council convened immediately following adjournment of the House of Delegates, Wednesday afternoon, September 27, 1950, in the west dining room of the French Lick Springs Hotel, with Dr. W. U. Kennedy, the chairman, presiding. Roll call showed the following members present:

Councilors:

First District	Herman T. Combs, Evansville
	Paul D. Crimm, Evansville, alternate
Second District	William C. Reed, Bloomington
Third District	William H. Garner, New Albany
Fourth District	George A. May, Madison
Fifth District	A. M. Mitchell, Terre Haute
	V. Earle Wiseman, Greencastle, alternate
Sixth District	W. U. Kennedy, New Castle
Seventh District	Roy A. Geider, Indianapolis
Eighth District	E. H. Clauser, Muncie
	T. R. Hayes, Muncie, alternate
Ninth District	Harry E. Klepinger, Lafayette
Tenth District	W. H. Howard, Hammond
	J. Robert Doty, Gary, alternate
Eleventh District	Elton R. Clarke, Kokomo
Twelfth District	M. B. Catlett, Fort Wayne

Officers:

C. S. Black, Warren, president
Alfred Ellison, South Bend, president-elect
Roy V. Myers, Indianapolis, treasurer

Members of Executive Committee:

W. L. Portteus, Franklin, chairman
C. J. Clark, Indianapolis
Albert Stump, Indianapolis, attorney
Ray E. Smith, Indianapolis, executive secretary
James A. Waggener, Indianapolis, field secretary

The following business came before the Council at this time:

1. *Dates for 1952 annual session in Indianapolis.* On motion of Drs. Mitchell and May, the executive secretary was given authority to make tentative reservation of dates for the 1952 annual convention which is to be held in Indianapolis.

2. *American Hospital Association attitude.* Discussion of the attitude of the American Hospital Association regarding the practice of medicine by hospitals resulted in the passing of a motion by Drs. Howard and Geider authorizing the sending of a telegram to the American Hospital Association, the American College of Surgeons, and to the American Medical Association, stating that the Council of the Indiana State Medical Association disapproves of the American Hospital Association taking over the grading and approval of hospitals.

3. *Establishment of a full-time health officer in Fayette county.* Dr. F. H. Neukamp of Connersville presented the details of this proposal to the Council. Following discussion by Drs. Portteus, Black, Combs, Doty, Ellison and Mr. Stump, on motion of Drs. May and Combs, the Council authorized the Executive Committee to advise with Dr. L. E. Burney, state health commissioner, on this matter.

No further business appearing, the Council adjourned.

HOUSE OF DELEGATES

(French Lick Session, 1950)

First Meeting

The House of Delegates convened in the main convention hall of the French Lick Springs Hotel, French Lick, Indiana, at 3:00 P.M., Monday, September 25, 1950, with the president, Dr. C. S. Black, presiding.

Dr. James M. Kirtley's motion that the attendance slips, signed by the delegates, constitute the roll call was seconded unanimously. These slips showed 104 delegates, 10 councilors, 8 ex-presidents, the president, the president-elect, and one A.M.A. delegate present.

THE CHAIRMAN: We have a quorum; therefore this House is declared open and ready for business.

The By-Laws may be amended at any annual convention by a *majority vote of all delegates present at that convention*, after the amendment has laid on the table for one day. That is, an amendment may be presented today and voted and passed on or rejected at the next meeting.

The House of Delegates may amend any article of the Constitution by a *two-thirds vote of the delegates present* at any annual convention, provided that such amendment shall have been presented in open meeting at the previous annual convention and that it shall have been published twice during the year in THE JOURNAL of this Association.

In Memoriam

The House stood for one minute in silent tribute to the memory of the following members, deceased since the 1949 session, who were members of the House of Delegates or who had served the State Association in some official capacity:

CHARLES AKER, Greencastle. Delegate from Morgan County, 1936; delegate from Putnam County, 1948.

WILLIAM R. DAVIDSON, Evansville. Secretary Vanderburgh County Medical Society 1908-1911; member of Committee on Pathology 1910 and 1911; delegate to American Medical Association 1911-1912; alternate delegate to American Medical Association 1912-1913; First District councilor 1904 through 1917, and 1924 through 1928; chairman of the Council 1913, 1914, 1915, 1916, 1925, 1926, 1927 and 1928; secretary of the Section on Medicine 1916; member of Committee on Public Policy and Legislation 1920; President of the Association 1922; member of Committee on Administration and Medical Defense 1922; member of Committee on Budget 1927 and 1928; member of Executive Committee 1928; member of Committee on Medical Education and Hospitals 1930-1932, and chairman in 1931; member of Medical Education Investigation Committee 1938; member of Committee on Postwar Medical Service 1945 and 1946.

O. E. GLICK, Kentland. Secretary Jasper-Newton County Medical Society 1918-1924.

C. A. HARTLEY, Sr., Evansville. Secretary Vanderburgh County Medical Society 1914.

E. E. HOLLAND, Richmond. Secretary Wayne County Medical Society 1918; chairman of Section on Ophthalmology and Otolaryngology 1936; member of Committee on Conservation of Vision 1939-1943, and chairman in 1940; member of Committee on Hard of Hearing 1943-1948.

B. F. KUHN, Elkhart. Secretary Elkhart County Medical Society 1918-1919.

F. G. McCARTHY, Terre Haute. Secretary Vigo County Medical Society 1914-1915.

B. W. MARSHALL, Nashville. Delegate from Bartholomew-Brown County Medical Society 1942.

W. J. MARSHALL, Kokomo. Secretary Howard County Medical Society 1930-1936.

C. C. MORRISON, Greensburg. Secretary Decatur County Medical Society 1926, 1927 and 1938.

D. A. MORRISON, Kokomo. Delegate from Howard County 1942.

T. B. NOBLE, Sr., Indianapolis. Member of Committee on Arrangements 1910-1911.

MARCUS RAVDIN, Evansville. Member of Committee on Conservation of Vision and Hearing, 1916.

I. M. SANDERS, Greensburg. Secretary Decatur County Medical Society 1915 and 1923; delegate from Decatur County 1942, 1944, 1945; member of Committee on Prepayment of Medical and Surgical Care 1945.

S. B. SIMS, Frankfort. Member of Committee on Public Relations 1937.

E. M. VAN BUSKIRK, Fort Wayne. First Vice-president of Association 1909-1910; Twelfth District councilor 1930-1937; Vice-chairman 1936, and chairman, 1937, Section on Medicine; President-elect 1938, and President of Association 1939; member of Executive Committee 1938 and 1939; member of Budget Committee 1938, 1939 and 1940; member Committee on Indiana Inter-Professional Health Council 1939 and 1940; member Liaison Committee with Indiana State Department of Public Welfare 1939; member of Committee on Control of Cancer 1945 and 1946.

(On motion of Drs. W. U. Kennedy, seconded by several, the minutes of the 1949 meetings of the House were approved as published in the December, 1949 JOURNAL.)

General Practitioner Award

Following a brief statement by Dr. W. U. Kennedy, chairman of the Council, concerning the nominees for this award, on motion of Drs. Catlett and Clarke, the chairman was authorized to appoint a screening committee to review the material submitted on each of the nominees, to choose the three most eligible candidates, and to present their names to the House of Delegates before adjournment of this meeting.

THE CHAIRMAN: I shall proceed to name the reference committees for this House of Delegates. Please stand until your entire committee has been named.

1. SECTIONS AND SECTION WORK:
   Jack Porter, Lebanon (Boone), chairman
   E. B. Jewell, Logansport (Cass)
   Robert H. Rang, Washington (Daviess-Martin)
   Carl Henning, Hanover (Jefferson)
   Walter Stout, New Castle (Henry)

2. RULES AND ORDER OF BUSINESS:
   Virgil McCarthy, Princeton (Gibson)
   F. M. Fargher, Michigan City (LaPorte)
   Robert D. Howell, Indianapolis (Marion)
   William Karsell, Bloomington (Owen-Monroe)
   M. C. Topping, Terre Haute (Vigo)

3. MEDICAL EDUCATION AND HOSPITALS:
   J. E. Dudding, Hope (Bartholomew-Brown), chairman
   Robert K. Webster, Brazil (Clay)
   A. S. Giordano, South Bend (St. Joseph)
   W. C. Wright, Fort Wayne (Allen)
   Roy V. Myers, Indianapolis (Marion)

4. PUBLIC POLICY AND LEGISLATION:
   Paul D. Crimm, Evansville (Vanderburgh), chairman
   R. R. Calvert, Lafayette (Tippecanoe)
   Davis W. Ellis, Rushville (Rush)
   A. M. Mitchell, Terre Haute (Vigo)
   Harold C. Ochsner, Indianapolis (Marion)

5. PUBLICITY:
   J. M. Kirtley, Crawfordsville (Montgomery), chairman
   C. C. Herzer, Evansville (Vanderburgh)
   Ray Elledge, Hammond (Lake)
   Oran A. Province, Franklin (Johnson)
   Orville A. Hall, Muncie (Delaware-Blackford)

6. HYGIENE AND PUBLIC HEALTH:
   Marvin L. McClain, Scottsburg (Scott), chairman
   John S. Hash, Noblesville (Hamilton)
   F. R. N. Carter, South Bend (St. Joseph)
   O. H. Stewart, Aurora (Dearborn-Ohio)
   O. T. Scamahorn, Pittsboro (Hendricks)

7. AMENDMENTS TO CONSTITUTION AND BY-LAWS:
   Cleon A. Nafe, Indianapolis (Marion), chairman
   Augustus P. Hauss, New Albany (Floyd)
   J. R. Nash, Albion (Noble)
   G. B. Wilder, Anderson (Madison)
   I. E. Huckleberry, Salem (Washington)

8. REPORTS OF OFFICERS:
   M. E. Glock, Fort Wayne (Allen)
   D. D. Dickson, Greensburg (Decatur)
   Richard P. Good, Kokomo (Howard)
   S. J. Petronella, East Chicago (Lake)
   James F. Reilly, Vincennes (Knox)

9. COMMITTEE ON CREDENTIALS:
   William E. Amy, Corydon (Harrison), chairman
   Milton Omstead, Petersburg (Pike)
   Carl F. Briggs, Sullivan (Sullivan)
   W. G. Pippenger, Brook (Jasper-Newton)
   William Dannacher, Wabash (Wabash)

10. COMMITTEE ON MISCELLANEOUS BUSINESS:
    B. M. Merrell, Rockville (Parke-Vermillion), chairman
    John M. Paris, New Albany (Floyd)
    Maurice V. Kahler, Indianapolis (Marion)
    James Burk, Decatur (Adams)
    H. P. Graessle, Seymour (Jackson)

11. COMMITTEE ON PREPAID MEDICAL INSURANCE:
    Elton R. Clarke, Kokomo (Howard), chairman
    Gerald S. Young, Muncie (Delaware-Blackford)
    A. A. Thompson, Tyner (Marshall)
    William C. Reed, Bloomington (Monroe)
    Gordon A. Thomas, Lafayette (Tippecanoe)

Reports of Officers

These reports, except for the address of the president and that of the president-elect, are printed in the September JOURNAL and in the Handbook, but each officer will receive five minutes in which to make any additional comments.

The president's address, to be made before the general assembly on Tuesday, will be referred to the Reference Committee on Reports of Officers.

ADDRESS OF THE PRESIDENT-ELECT

DR. ALFRED ELLISON: Mr. President and Members of the House of Delegates:

For the privilege of serving the State Medical Association as its President for the year beginning with the last day of this convention, I am indebted to you gentlemen of the House of Delegates. I thank you again for this very considerable honor and for this opportunity. It is an unusual opportunity which this office affords to serve the physicians of our state. In doing so I ask for the help and guidance and friendship of each of you throughout the year. After serving in the Council for a dozen years, one becomes very aware that our affairs are conducted by teamwork on the part of many. Being on this team for the past twelve years has been a most happy experience and one which I shall always cherish. I am grateful to the many friends made during this period, for their friendship and example, and for their idea that I could do the job you have honored me with this year.

We are living through a critical period in the history of medicine and in the history of our country. It is a time when each of us must stand up and be counted. There has been no time when it was more important that we conduct ourselves as good doctors and at the same time as patriotic Americans. If free medicine and if free America are to survive, and I am confident they will, we each must become militant patriots.

Doctor Black has wisely pointed out repeatedly during the past year the fundamental importance of honestly serving the public. If every patient leaves his doctor firm in the belief that he has been honestly and fairly served we will have many and powerful allies on our side. If each of us in Indiana sees but an average of twenty patients a day this means contact daily with 75,000 persons by Hoosier doctors. This influence, if exerted, can be tremendous in the cause of clear thinking and of good voting.

While the effort to socialize the doctors of America by our present government has been going on, we have witnessed the spectacle of encroaching subjugation of some of our own profession by hospitals and even by other physicians. The physicians especially subjected to this treatment have been the pathologists, anesthesiologists and roentgenologists. But in some other states surgeons and obstetricians have fallen prey and are on salaries from hospitals. The moral is that no group is exempt from this possibility. The American Hospital Association has publicly stated its views on this matter. They contend they may hire doctors and practice medicine. Their ambitions must be recognized and dealt with. The American Medical Association at the San Francisco convention took recognition of this growing threat to the freedom of private practice of medicine. The report of the so-called "Hess Committee" clearly states that no corporation, including hospitals, may ethically employ a physician and resell his services on a fee basis. The House of Delegates of the American Medical Association approved this report. Our own state Executive Committee last April passed a similar resolution and in July our Council approved this. And during the deliberations of this House of Delegates you will be asked to consider this resolution. The issue is clear. We must set the pattern now with firm action, or else in the years to come hospitals, and not private physicians, will treat the sick of our state and country. Our socialization and subjugation by hospitals is a thing we cannot tolerate. The generations of doctors who will follow us will have their fate in this matter determined by our recognition of this threat and by our resolute action today.

The program of the American Medical Association in its effort to save the physicians of America from Federal socialization should have the wholehearted support of every doctor in the country. Let us not forget that there are numbers of our fellow practitioners who are devoting a very considerable part of their time to this cause at a great sacrifice, a sacrifice not only of their time and energies but of their incomes. Each of us has been asked to pay $25 into a fund. This is a paltry amount indeed when it is realized that our very way of life and our livelihood is at stake. Yet in spite of this, only 2,160 of our state association members have supported the American Medical Association as of this date. In other words, 1,400 Indiana physicians have refused or neglected to join the A.M.A. By not paying dues they are impeding the program of the American Medical Association and may be the cause of our state losing one of its four national delegates after 1951. In these very critical times everyone should carry his share of the burden and be happy for the opportunity to do so. We have so much at stake. Tomorrow may be too late.

The officers and directors of our Blue Shield Insurance Company are to be commended for the successful conduct of this company. This is one specific answer Indiana medicine can give to advocates of compulsory insurance. No other feature of our program deserves more support from every doctor in the state than this. In modest income groups we will all be serving the best interests of everyone concerned if we accept the fees paid by Blue Shield as full payment for the services they cover. The Blue Shield policy of raising the schedule of fees towards this end, as their assets permit, is farsighted and wise. But the physicians of Indiana should cooperate in accepting these fees as full payment in appropriate cases or else we will be guilty of avarice and bad intention. There never has been a more important time for each of us to conduct himself for the good of the whole.

The shortage of nurses continues to be a serious

problem in every section of the state. Patients have learned to expect less care than they received in former years but at times now this care is so inadequate that the patient's welfare is impaired. Many factors are involved in causing this serious shortage of nurses. Our state association has officially recognized this problem for the past two years with some degree of improvement. It will be my intention, this coming year, to ask the Woman's Auxiliary to take over, as one of its major projects, the stimulation of enrollment of young women in the nurses training courses in the various hospitals of the state. Individual physicians, too, are obviously in an excellent position to guide young women into such careers.

The physicians of Indiana should be aware of the concerted effort which will be made by the chiropractors to obtain a separate licensing board from our state legislature this year. They have employed expert talent and are spending large sums to accomplish this end. The physicians of Indiana are against the unbridled licensing of chiropractors for one reason only. And that reason is that they do not have adequate medical education. It is the welfare of the public, and not the welfare of those who want to be practitioners, that is the concern of the State Medical Board.

The problem of rural health is one which confronts the medical professions of every state. The distribution of physicians in rural areas, in fact, is said by our critics to be one of our deficiencies. The problem in Indiana is obviously not as great as it is in some states but we must bear in mind that Indiana is approximately half rural and that we do have some areas in the state where more or better medical facilities are needed. Our state association should recognize this problem somewhat more actively, I believe, in the hope of being of assistance to communities who desire this care. The matter is of such importance that I would like to recommend to the House of Delegates that the Committee on Rural Care in Indiana be made a standing committee.

I wish to take this opportunity to tell Doctor Black of the sincere appreciation which I feel for the many courtesies extended by him during this past year and that it has been a real pleasure to work as an apprentice under him.

Those of us who have the good fortune to work closely with the lay personnel of our state office are constantly being made aware of the outstanding people we have in our organization. I cannot let this opportunity pass to express my appreciation to Ray Smith, especially, and to Jim Waggener, Miss Kribs, Mrs. Rowlison, Miss Reid, and the others of our headquarters office who have made our work in the association so pleasant. I sincerely believe that our association could search for a long time before it would find personnel with equal talents and devotion to our organization.

May I emphasize to you that we physicians have a much larger responsibility than most citizens because we have become so acutely aware of encroaching socialism? We have a singular responsibility to all other fellow Americans to alert them to the peril we see all around. We must spearhead the renaissance of freedom.

We must squarely face the fact that the socialization of medicine is merely a part of the plan to socialize all of America. Let us not be afraid honestly to appraise the situation that exists today in our country. Over this land there has grown a cloud in the past few years—an ominous cloud that fills us all with fear and apprehension. We have seen our government infiltrated by forces and influences foreign to the American way of life. We have seen our elected representatives fall prey to the influence of men who would destroy America. That these men are the tools—wittingly or unwittingly—of an international conspiracy we call Communism, no one with courage can deny. How far has this malignant influence affected us to date? Let us candidly face some of the facts. The total government expenditure under the first 32 presidents, covering a period of 156 years, is a total of 179 billion dollars. It is alarming to know that in the past five years under the present administration expenditures exceed 191 billion dollars. Twelve billions more in the past five years than in the preceeding 156 years! Can any sane person disregard this? The public debt has risen to over a quarter of a trillion dollars. In eighteen of the past twenty years the government has spent more than it has taken in. This reckless policy continues and a day of reckoning is inevitable. If all the life insurance policies in America were converted to cash they would support the Federal Treasury for but one year. If all the homes in every city of the land were sold this money would last but eight months in paying the Federal bills. If all the farms, farm animals and equipment in all the states were sold this sum would only supply money for current expenses in Washington for seven months. The average man now works fifteen weeks out of every year to satisfy the tax demands of our government. The value of a $10,000 life insurance policy in 1940 has today shrunk to $6,000 as a result of a dilution of our currency, and the end of this trend is not in sight. My attorney friends tell me that it is practically impossible, under existing laws, for a parent to pass wealth to his descendants upon his death. We have seen an unwarranted domination of America by the executive branch of government, manifested by 2¼ million Federal civilian employees who are, by and large, bureaucrats. The position of the legislative and judicial branches has, at the same time, suffered in stature. The effort to pack the Supreme Court is a matter of history.

There are some things in life, we, as individuals, can do little about. But this all-important matter of socialization of America and the gradual loss of our freedoms is one we can and must do something

about. In Dante's Inferno we read, "The hottest place in Hell is reserved for those, who in time of crisis, retain their neutrality." No sane person can deny that we are passing through a major crisis in our history. It is long past time that we quit thinking as members of a political party but to think as Americans, for the America that we have known is fast slipping from us. If those of you who have children love these children, and want them to have a decent future, you must recognize this crisis. The spirits of the patriots who gave us this land, the Washingtons, the Jeffersons and the Lincolns, must be anxiously watching over us from some vantage point today, wondering what kind of citizens we will turn out to be. The spirits of these ancestors must be pleading that each of us awakens to his responsibility in this hour of crisis, pleading that we awaken before our opportunity to salvage our country is gone.

We must get rid of the fixed idea that liberty is imperishable in our country. You may ask yourself just what liberties have we lost so far. Let me remind you that you have lost the liberty to keep and use or to save that which you earn. And you have lost even a greater freedom, and that is the freedom of your ballot, because the votes of six or seven million of our citizens are neutralized by the political machine made up of 2¼ million bureaucrats and their families. The loss of other liberties is a matter they are asking our Congress to approve.

We may hope that the threat of this world-wide conspiracy serves so to alarm our people over the loss of their freedoms as to cause a revival of the old-time patriotism which inspired our ancestors. The patriotism which created America and which jealously guarded it in its infancy. We have grown complacent, and in a democracy we dare not be complacent. America was not founded by weaklings; our heritage of freedom was won by men who bled and died that we might enjoy the blessings of the greatest country in all the world's history. We would be poor men indeed if we failed to fight now to retain these blessings for ourselves and our posterity.

(Referred to Reference Committee on Reports of Officers.)

Reports of the Executive Secretary, the Treasurer, the Chairman of the Council, and the councilors, were referred to the Reference Committee on Reports of Officers.

Supplementary Report of Chairman of the Council

Dr. W. U. Kennedy presented the following matters which were referred by the Council to the House of Delegates:

1. *Report of Special Committee on Disability Insurance.* (See complete report on pages 1119 to 1121, Council minutes.) This report was approved by the Council with the recommendation that it be adopted by the House of Delegates. (Referred to Reference Committee on Miscellaneous Business.)

2. *Final report of the Special Committee on Income Pension Plan.* (See page 1122, Council minutes.) The Council approved this plan at its July 16, 1950, meeting, and it is presented at this time for approval of the House of Delegates. (Report read by Dr. E. R. Clarke, chairman, and referred to Reference Committee on Miscellaneous Business.)

3. *Recommendation of the A.M.A. Campaign Coordinating Committee* that this committee be continued next year, and that state dues remain at $35.00, approved by the Council. (Referred to Reference Committee on Public Policy and Legislation.)

4. *Payment of A.M.A. dues.* Indiana members are not paying A.M.A. dues in sufficient numbers to insure the retention of four Indiana delegates in the A.M.A. House of Delegates. (Referred to Reference Committee on Miscellaneous Business.)

5. *Resolution regarding enlargement of Indiana University School of Medicine.* Approved by the Council. (See page 1130.)

Reports of Standing and Special Committees

THE CHAIRMAN: These reports are printed in the September JOURNAL and in the Handbook, but each chairman will receive five minutes in which to make any additions or explanation to the reports already published, if he so desires.

Executive Committee — Referred to Reference Committee on Reports of Officers.

Constitution and By-Laws—Referred to Reference Committee on Amendments to the Constitution and By-Laws.

Convention Arrangements—Referred to Reference Committee on Miscellaneous Business.

Industrial Health—Referred to Reference Committee on Hygiene and Public Health.

Medical Education and Hospitals—Referred to Reference Committee on Medical Education and Hospitals.

Public Policy and Legislation—Referred to Reference Committee on Public Policy and Legislation.

Public Relations—Referred to Reference Committee on Public Policy and Legislation.

Sub-committee on Grievances—Referred to Reference Committee on Public Policy and Legislation.

Committee on Publicity—Referred to Reference Committee on Publicity.

Scientific Exhibits—Referred to Reference Committee on Sections and Section Work.

Scientific Work—Referred to Reference Committee on Sections and Section Work.

Auditing Committee — Referred to Reference Committee on Reports of Officers.

Cancer—Referred to Reference Committee on Hygiene and Public Health.

Conference of County Medical Society Officers—Referred to Reference Committee on Miscellaneous Business.

Conservation of Vision—Referred to Reference Committee on Hygiene and Public Health.

Crippled Children Services—Referred to Reference Committee on Public Policy and Legislation.

Diabetes—Referred to Reference Committee on Hygiene and Public Health.

Emergency Medical Service—Referred to Reference Committee on Miscellaneous Business.

Hard of Hearing—Referred to Reference Committee on Hygiene and Public Health.

Heart Disease—Referred to Reference Committee on Hygiene and Public Health.

Indiana A.M.A. Campaign Coordinating Committee—Referred to Reference Committee on Miscellaneous Business.

Indiana Inter-Professional Health Council—Referred to Reference Committee on Miscellaneous Business.

Indiana Military Manpower—Referred to Reference Committee on Miscellaneous Business.

Infantile Paralysis—Referred to Reference Committee on Hygiene and Public Health.

Instructional Courses — Referred to Reference Committee on Sections and Section Work.

Maternal and Child Health—Referred to Reference Committee on Public Policy and Legislation.

Medical and Nursing School Scholarships—Referred to Reference Committee on Medical Education and Hospitals.

Mental Health—Referred to Reference Committee on Hygiene and Public Health.

Necrology—Referred to Reference Committee on Publicity.

Prepaid Medical and Hospital Insurance—Dr. Augustus P. Hauss, chairman, presented the report of the committee as printed in the Handbook and the following supplementary report, which were referred to the Reference Committee on Prepaid Medical Insurance:

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Board of Directors of Mutual Medical Insurance, Inc., in regular session July 30, 1950, voted unanimously to request this House of Delegates to authorize Mutual Medical Insurance, Inc., to offer a Service Plan contract in addition to its present Indemnity Plan.

Your committee, as the liaison agency between Blue Shield and our association, was asked to present the request in the form of a resolution. A special meeting of your committee was called to consider this request and the proposed resolution.

In order that all might know of the action pending before this House of Delegates, a pamphlet containing a copy of the proposed resolution and informative data regarding Service Plan Insurance was authorized to be printed and mailed to all members of the Indiana State Medical Association.

This Committee, the Field Secretary of the Indiana State Medical Association, and the Executive Vice-President of Mutual Medical Service, Inc., jointly share the responsibility for the issuing and preparation of this pamphlet.

Following the issuing of this pamphlet, a special meeting of your Committee on Prepaid Medical and Hospital Insurance was held today and we respectfully present to this House of Delegates the following report and recommendations.

We believe that the pamphlet on Service Plan Insurance does not clearly define the plan or its operation and that the pamphlet is more confusing than informative.

We believe that the phrasing of the proposed resolution may appear contradictory to statements in the accompanying printed matter.

We believe that the members of the Indiana State Medical Association should be thoroughly informed on Service Plan insurance and its operation before any action is taken by the House of Delegates.

We therefore decline to present the proposed resolution in its present form or move its adoption at the present time.

We further believe that the Indiana State Medical Association should give serious consideration to the request of Mutual Medical Insurance, Inc., to add a service contract to its present medical care insurance plans.

Recognizing the fact that seventy-eight out of ninety-seven physician-sponsored medical insurance plans are now offering Service contracts, and that seven others have received approval to change to a Service Plan, and that eight more State Medical Association sponsored plans, including Indiana, are now considering the adoption of a Service contract in order to present a united front against socialized medicine, your Committee on Prepaid Medical and Hospital Insurance respectfully presents the following recommendations:

1. That this House of Delegates instruct the Board of Directors of Mutual Medical Insurance, Inc., after an exhaustive study of present Service plans to prepare a brochure defining the meaning of "Service Contract" and explain in detail its operation and provisions, and to state specifically their reasons for requesting the privilege of offering a Service

Contract in addition to the present Indemnity Plan.

2. That this brochure be mailed by Mutual Medical Insurance, Inc., to every member of the Indiana State Medical Association.

3. That at least sixty days be given to the members of the Indiana State Medical Association and the component County Societies to study this brochure.

4. That following the expiration of this sixty day period, the president of the Indiana State Medical Association issue a call for a special meeting of the House of Delegates to consider the approval of a Service contract.

Rural Health—Referred to Reference Committee on Public Policy and Legislation.

School Health and Physical Education—Dr. B. N. Lingeman, chairman, presented the report of the committee as contained in the Handbook and the following supplementary report, which were referred to the Reference Committee on Hygiene and Public Health:

Due to the imminent danger of another world war, and in order to remove some of the pressure for more radical changes in our practice, the Committee on School Health and Physical Education feels that an expanded school health program, affecting the health of about 700,000 future citizens, is of sufficient importance to warrant an attempt to speed up the program, and therefore wishes to make this supplementary report.

Some of the things that we might expect from such a modern health program are as follows: a better idea of scientific medicine, better nutrition, better posture and physical endurance for all the children, better health habits, better understanding of emotional problems, better preparation for parenthood, better determination of remedial defects with proper follow-up, better immunization program, better ideas of public health and sanitation, etc. I don't see how we can hope to reach the great mass of people especially before their ideas become fixed, except through such a school health program. This is a program which can be carried out without regimentation of our profession and without killing the initiative of the people.

A report printed in *The Pennsylvania Medical Journal,* March, 1949, states that in their school health program, remedial defects were found in from 40 to 80 percent of the children, depending upon the district and the number of corrections which had been made. Already many thousands of corrections had been made, mainly by family physicians and dentists. In their program they have fine cooperation from the physicians, and in one year over 1,500 physicians gave 222,000 hours of service for which they were paid from state funds. How can we say that our health program is as good as it might be when so many school children have remedial defects?

Some time ago our committee sent out a letter to all the county societies, asking that a committee on public and school health be appointed and that at least one program a year be given over to a joint discusion of school health problems with school authorities, school nurses, health and physical education teachers. A recent survey would indicate that so far very few societies have carried out this suggestion.

In a recent meeting with some lay members I was told by the state leader in the P.T.A., a woman with a lot of influence, that while she wanted to stand up for the medical profession, she had been much disappointed in the lack of cooperation she had received from certain members of the profession. If our physicians would only realize what a wonderful opportunity this is of developing good will among thousands of future voters, as well as among teachers and parents, I am sure they would find time to participate in the program.

Our committee has felt free to call in authorities in this field, who might be of help in planning a program. An extensive survey on the teaching of health in the elementary and secondary schools is being conducted under the supervision of Dean Patty, of the Department of Health Education of Indiana University. Along with this will be a survey of the teaching of nutrition and food habits of the school children, under the supervision of Dr. Cecila Schuck, Purdue University Department of Nutrition. While our studies are not yet complete, we will probably propose the following points, and if approved by the Executive Committee, will want the support of the entire medical profession. There may be other points later on:

(1) Make an effort to speed up the consolidation of schools, since a good health program in the smaller schools is both difficult and unduly expensive.

(2) Advocate a fearless re-examination of the curriculum, with the idea of putting first things first, including health, and develop a curriculum that will better meet the needs of present-day living.

(3) Make the State Superintendent of Public Instruction an appointive office for at least four years and give the department sufficient funds to carry out research and surveys to give our schools the leadership they should have.

(4) Attract into the program by higher salaries and scholarships, where necessary, the nurses, dental hygienists, health teachers, dentists and physicians, either full or part time, needed to carry out the program.

We wish to report that already one county (Montgomery), with the help of the State Board of Health, is giving dental examinations to all the children, and sodium fluoride treatments to all the children of the second, fifth, and eighth grades

over the entire county. It is expected that this program will reduce dental caries at least 40 percent. We have had excellent cooperation from local dentists who feel that they should not be wasting their time filling cavities or extracting teeth of children which could be prevented. This program was sponsored by the Montgomery County Health Council. In supporting this school health program we will have the opportunity to work not only for the common welfare but also for ourselves. The strength of any nation is dependent upon the health of the people.

State Fair—Dr. Malcolm O. Scamahorn, chairman, presented the report of the committee as printed in the Handbook and the following supplementary report, which were referred to the Reference Committee on Publicity:

The committee wishes to supplement its September report. Our background exhibits at the State Fair were on the number of persons per unit of population in each state covered by voluntary insurance, diseases caused by animals, and danger of the rat. Mrs. Reed, president of Marion County Auxiliary, provided hostesses to monitor the blood pressure line and hand out literature in regard to voluntary insurance and related subjects. Four medical students recorded between 10 and 11 thousand blood pressures during Fair Week. We know by correspondence with our four neighboring state societies that our exhibit was the most heavily attended of any type shown to a lay group. This committee wishes to thank Mr. Ray Smith and Mr. James Waggener for their excellent help.

Traffic Safety—Referred to Reference Committee on Hygiene and Public Health.

Tuberculosis—Referred to Reference Committee on Hygiene and Public Health.

Venereal Disease—Referred to Reference Committee on Hygiene and Public Health.

Veterans Affairs and Rehabilitation—Referred to Reference Committee on Miscellaneous Business.

JOURNAL *Editor*—Referred to Reference Committee on Reports of Officers.

NEW BUSINESS

1. *Resolution regarding enlarging I. U. School of Medicine.* Dr. W. U. Kennedy, New Castle, presented the following resolution, which was referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, the medical profession of Indiana is deeply aware of its responsibility to provide adequate medical care and assistance for the citizens of the State of Indiana, and,

WHEREAS, medical services in a number of communities, especially in the rural areas, would be improved if more physicians were available for the private practice of medicine, and,

WHEREAS, the Indiana University School of Medicine, the state's only medical school, is the principal source of physician supply for Indiana, and is now operating at its full capacity, and

WHEREAS, the Board of Trustees of Indiana University will again present plans for expanding and improving medical education facilities at the Indiana University School of Medicine at the next session of the Indiana General Assembly; *Now Therefore*

Be It Resolved, That the Delegates of the Indiana State Medical Association do hereby urge the 87th General Assembly of the State of Indiana to appropriate necessary funds in order that the Indiana University School of Medicine may enlarge its facilities and add to its faculty so its enrollment can be increased sufficiently to meet more nearly the physician needs of the state;

That a copy of this resolution be forwarded to the members of the Budget Committee of the State of Indiana, and each holdover Senator and each Senator and Representative elected to the 87th General Assembly on November 7 receive a copy of this resolution. Also, that a copy be sent to the members of the Committee on Medical Education and Hospitals of the American Medical Association.

2. *Resolution on Dr. A. F. Weyerbacher.* Dr. Robert D. Howell, Indianapolis, presented the following resolution, which was referred to the Reference Committee on Miscellaneous Business:

WHEREAS, Doctor A. F. Weyerbacher has faithfully served as treasurer of the Indiana State Medical Association for the past nineteen years, and

WHEREAS, he has given unstintingly of his time and advice, and

WHEREAS, on account of impaired health, he now requests to be relieved of his duties as treasurer; *Therefore, Be It*

Resolved, by the House of Delegates of the Indiana State Medical Association that the Association extend to Dr. Weyerbacher its sincerest thanks and gratitude, and *Furthermore, Be It*

Resolved, that the Executive Committee be empowered to procure a memento and present it to Dr. Weyerbacher as a token of appreciation of the State Association.

3. *Resolution on section meetings.* A resolution sponsored by the Section on Ophthalmology and Otolaryngology, asking that section meetings be held during the annual convention, was referred to the Reference Committee on Sections and Section Work.

4. *Resolution on amendment of Indiana premarital blood test law.* Dr. J. R. Doty, Gary, presented the following resolution, which was referred to the Reference Committee on Public Policy and Legislation:

WHEREAS, the frequent delay incurred in postal delivery of blood specimens to testing laboratories under the Indiana pre-marital blood test laws results in the hemolyzation of the specimen, and

WHEREAS, the further delay thereupon imposed in obtaining additional specimens is neither desirable nor intended by the profession or the State Legislature at the time of the adoption of the law,

Now Therefore, Be It Resolved, that the House of Delegates of the Indiana State Medical Association, through its Legislative Committee, present to the next session of the Indiana General Assembly a bill to amend the existing law in such a manner as to permit the delivery of blood specimens directly to the laboratories for examination, at the same time retaining the requirement that the report of the results of the examination be mailed to the physician.

5. *Resolution from Indiana Society of Anesthesiologists, Indiana Association of Pathologists and Indiana Roentgen Society.* Dr. D. D. Stiver, South Bend, introduced the following resolution, which was referred to the Reference Committee on Prepaid Medical Insurance:

WHEREAS, The report of the Committee on Hospitals and the Practice of Medicine of the American Medical Association, commonly referred to as the Hess Report, was adopted by the House of Delegates at its meeting in San Francisco in June, 1950, and

WHEREAS, The "Hess" committee report as adopted by the House of Delegates of the American Medical Association states that "the practice of anesthesiology, pathology, physical medicine, and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine, or any other designated field of medicine," and

WHEREAS, We physicians of Indiana and members of the American Medical Association accept and concur with the policy stated above;

Therefore, Be It Resolved, that the Delegates of the Indiana State Medical Association re-affirm the principles of ethics of the American Medical Association, and

WHEREAS, The "Hess" committee recommended that Blue Shield and Blue Cross be requested to cooperate to the extent of writing all new contracts in such a manner that Blue Shield will cover insurable medical services and Blue Cross will cover insurable hospital services, and

WHEREAS, Blue Shield contracts in Indiana are covered by Mutual Medical Insurance, Inc., and

WHEREAS: This Insurance plan is approved by the Indiana State Medical Association;

Be It Further Resolved, The House of Delegates of the Indiana State Medical Association urge Mutual Medical Insurance, Inc., to include in their future contracts insurable services that are an integral part of the practice of medicine, including anesthesiology, pathology, radiology and physical medicine.

6. *Resolution to amend Constitution to make councilor districts conform with Congressional districts.* Dr. Mier Bizer, Jeffersonville, presented the following resolution, which was referred to the Reference Committee on Amendments to Constitution and By-Laws:

WHEREAS, It is considered desirable that the medical districts should conform to the congressional districts of the state of Indiana, and

WHEREAS, There will be a redistricting of the state of Indiana after the 1950 census, *Therefore Be It*

Resolved, That the Indiana State Medical Association make the necessary changes to cause these districts to conform with the congressional districts of the state of Indiana when the new districts are set up and, *Be It Further*

Resolved, That the procedure be followed whenever new congressional districts may be formed.

7. *Address by Dr. L. E. Burney, secretary, and state health commissioner, Indiana State Board of Health.* Referred to Reference Committee on Public Policy and Legislation.

THE INDIANA STATE BOARD OF HEALTH AND THE MEDICAL PROFESSION

In 1849 the Indiana State Medical Society, organized that same year, passed the following resolution: "*Resolved,* That a committee of five be appointed to memorialize the state legislature asking them to provide by law for a registration of births, marriages, and deaths." In 1875 a committee of five was appointed by the State Medical Society to study problems relating to the establishment of a State Board of Health. The committee drafted a bill for the establishment of a State Board but the bill failed. These two early actions by our State Medical Society symbolize the interest and leadership of the physicians in Indiana in the development and continued operation of the State Board of Health. This interest, understanding, and support have continued and have been strengthened throughout the years with benefit to both organizations and to the people of our state.

Public health and preventive medicine have come a long way since the State Board of Health was established by law in 1881. There is a closer partnership between the practicing physician and the public health worker. On our part we recognize the skills, the experiences, and the indispensable services of the practicing physician in public health and preventive medicine. The physician, too, is recognizing the importance of preventive medicine in his practice. The medical care group of the Hoover Commission made the following pertinent statement: "The necessity for medical care which requires heavy expenditures and much personnel must not be permitted to result in minimizing the even greater importance of controlling disease."

The State Board of Health today is a professional organization. Its policies are established by the nine-member board appointed by the Governor of the State. Consisting of three physicians, a dentist, a pharmacist, an engineer, a veterinarian, a nurse, and a layman, it is the board which selects the State Health Commissioner. He, together with the staff, administers the public health program for the state. Dr. Jacob T. Oliphant of Farmersburg, a past president of the association, is the chairman of the board. All employees of the State Board of Health, engineers, physicians, dentists, veterinarians, nurses, sanitarians, educators, et cetera, must meet the State Merit System standards of professional training and experience and qualify for their positions through open competitive examinations.

The board has adopted some general policies with reference to our relationship with other organizations and also with reference to the specific functions. These are of interest and concern to the medical profession:

WORKING RELATIONSHIPS

The State Board of Health recognizes the major role that the medical and allied professional groups play in public health improvement and the contributions they have to make. Cognizance of this fact is evident in the close liaison existing between the State Board of Health and these groups. Every effort will be made to continue and strengthen this

effective relationship. The interest, understanding, and support of these professional organizations are essential and will be solicited. Their assistance will always be sought in studying and analyzing public health problems, planning their solutions, and establishing desirable administrative methods and techniques. The Executive Board and the administrative staff fully recognize that the solution to public health problems lies not in the hands of one individual, one agency, one group, or one profession, but requires the combined skills and services of all in one degree or another.

The State Board of Health will continue to work closely with the local professional groups and the voluntary health organizations in all public health programs affecting a local area, appreciating the fact that any public health program—to be effective—must have the understanding and support of all such groups.

General Policy

The Indiana State Board of Health is committed by laws and regulations to the following general responsibilities:

1. To provide state-wide leadership and stimulation in all matters relating to public health improvement.

2. To accept the principle that local health service—through a full-time local health department, staffed by full-time, well qualified professional personnel—is the most effective and economical method for meeting most local public health problems.

3. To assume that it has a partnership interest in the local health work and a responsibility to provide consultatory service.

4. To administer financial grants-in-aid to local health departments.

5. To provide leadership to colleges, elementary and secondary schools, voluntary health agencies, civic groups, and service clubs for the purpose of assisting them in developing sound and scientifically correct health education programs.

6. To assume responsibility for those services which may be carried out most efficiently on a state-wide basis or where no authority exists for delegating responsibilities. In providing these direct services, however, the local health service will be recognized and utilized to the fullest extent.

7. To work toward the coordination and integration of all official state governmental public health functions in the interests of efficiency and economy, and to avoid duplication and overlapping of activities with other state departments whose major functions are in an entirely different area.

8. To determine the need in public health training and indicate the special fields that need developing and strengthening, and to give to the training institutions every assistance possible in providing such educational opportunities.

Conclusion

It is hoped that this brief presentation will give to you a better understanding of the organization, policy, and functions of the Indiana State Board of Health. It is hoped that this better understanding will result in effecting an even closer relationship between the practicing physician and those of us engaged in public health and minimize the difficulties and misinterpretations that occasionally arise.

Public health is no longer an infant son in the medical family. It has matured and has earned recognition with the medical specialties. The creation of a specialty board of Preventive Medicine and Public Health is evidence of this recognition. People today are more health conscious than ever before. They want and demand sound public health services. We who have devoted our lives to the field of medicine appreciate the logic of this request. Recently, Dr. Elmer L. Henderson, President of the American Medical Association, stated, "We doctors also know that public health has enormously aided our fight against death. . . . Dr. Louis H. Bauer, Chairman of the Board of Trustees of the American Medical Association points to large areas lacking public health services." This demand emphasizes the real need for the local medical profession to participate in local planning and provide constructive, progressive, and enlightened leadership to their communities. The training and experience of the physicians qualify them for this responsibility. If this leadership is not given, we cannot be too critical of the efforts of the laity and the mistakes they are sure to make.

The members of our staff welcome the opportunity to meet with your local and district medical societies to discuss the specific programs and to have the benefit of your suggestions and comments. It is true that all new programs of the State Board of Health are discussed with the committees of the State Medical Association and are presented either to the Council or to the Executive Committee for understanding and support. It would be helpful, however, to have an opportunity to discuss our activities with the members of the local medical societies in their own communities, and we hope you will feel free to ask me or any of the members of our staff to participate in your society meetings.

8. *Resolution memorializing the Congress of the United States with respect to a national compulsory sickness insurance program.* The following resolution, which was adopted by the Council at its meeting on July 16, 1950, was read by Dr. E. R. Clarke, Kokomo, and referred to the Reference Committee on Public Policy and Legislation:

Whereas, The American people now enjoy the highest level of health, the best standards of scientific medical care and the finest medical institutions ever attained by any major country in the world; and

Whereas, These accomplishments of American medicine

are the results of a free profession, working under a system of free enterprise; and

WHEREAS, The experience of all countries where government has assumed control of medical care has been a progressive deterioration of medical standards and medical care, to the detriment of the health of the people: *Now, Therefore, Be It*

Resolved, By the members of the Indiana Legislature in eighty-seventh session assembled, a majority of the members agreeing thereto:

1. That the Legislature of the State of Indiana respectfully request the Congress of the United States to refrain from imposing upon the citizens of the nation any form of compulsory insurance, or any system of medical care designed for National bureaucratic control.

2. That Indiana Senators and Representatives now in the Congress of the United States be and are hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation.

3. That copies of this resolution be transmitted by the Clerk of this Legislature to the President of the United States, the presiding officers of the United States Senate and United States House of Representatives and to each Senator and Congressman from Indiana.

9. *Resolution Concerning the Hess Report.* The following resolution was read by Dr. A. S. Giordano, South Bend, and referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, The "Hess" committee made a report to the House of Delegates of the American Medical Association in June, 1949, in Atlantic City regarding the practice of medicine by hospitals or other corporations, and

WHEREAS, The "Hess" report states, "therefore, hospitals and medical schools cannot charge patients fees for medical services rendered by physicians even though the physicians are full time employees of an individual or institution," and

WHEREAS, The "Hess" report was adopted by the American Medical Association House of Delegates, and instructions were given to the Trustees of the American Medical Association to enforce the matters and principles contained in the report, and

WHEREAS, The House of Delegates of the American Medical Association in December, 1949, convened in Washington, D.C., again confirmed the principles contained in the "Hess" report and directed that action by the Trustees deriving from this report be delayed only until legal requirements were investigated and met so that all actions taken would comply with the law, and

WHEREAS, The "Hess" committee is to report its further study to the House of Delegates in San Francisco in June, 1950, and likewise the Trustees of the American Medical Association are to report at this convention, and

WHEREAS, It is apparent to the physicians of Indiana that since the position of medical practitioners in the fields of anesthesiology, pathology and roentgenology has been subjugated by many hospitals and other corporations, the attitude and ambitions of such officials will logically lead to the same subjugation of other physicians practicing in other special fields of medicine, and

WHEREAS, This subjugation of the aforementioned specialists serves to discourage high quality individuals from entering these specialties in adequate numbers, and

WHEREAS, These aforementioned basic medical services, if rendered on a high plane, constitute the keystone of good medical service in a community, and

WHEREAS, In America there is developing, even among some physicians in local authority, the philosophy that groups of physicians may ethically band together to employ and subjugate fellow physicians, which is beneath the dignity of professional practice,

Therefore, Be It Resolved, The House of Delegates of the Indiana State Medical Association affirms the principles enunciated in the "Hess" report, and

Be It Further Resolved, The House of Delegates of the Indiana State Medical Association requests the House of Delegates of the American Medical Association to delay no longer in accomplishing the enforcement of Section 6, Article VI, Chapter III of the Principles of Medical Ethics, and

Be It Further Resolved, That the House of Delegates of the American Medical Association take cognizance of the fact that while the physicians of America are opposing their subjugation by the present Federal Government we are witnessing the subjugation of certain segments of our own profession, instituted or condoned by other members of our profession.

Election of Indiana "General Practitioner of the Year"

Dr. John W. Strange, of Loogootee, was elected "General Practitioner of the Year" by ballot vote.

No further business appearing, the House of Delegates adjourned, to meet again at 11:30 A.M. Wednesday, September 27, 1950, in the west dining room of the French Lick Springs Hotel.

HOUSE OF DELEGATES

(French Lick Session, 1950)

Second Meeting

The second meeting of the House of Delegates, a luncheon meeting, was held on Wednesday, September 27, 1950, in the west dining room of the French Lick Springs Hotel, at 11:30 a.m., with the president, Dr. C. S. Black, presiding.

It was taken by consent that attendance slips signed by the delegates, showing 105 delegates, 13 councilors, 10 ex-presidents, the president, the president-elect, the assistant treasurer and two A.M.A. delegates present, should constitute the roll call.

THE PRESIDENT: We have a quorum present; therefore we shall proceed with the election of officers.

Election of Officers

Election of officers resulted as follows:

President-elect, 1950-51 ——— J. William Wright, Indianapolis
Treasurer, 1950-51 ——— Roy V. Myers, Indianapolis
Assistant Treasurer, 1950-51 ——— John M. Whitehead, Indianapolis
Delegates to A.M.A., for term expiring December 31, 1952 ——— H. G. Hamer, Indianapolis
A. S. Giordano, South Bend
Alternates ——— Karl R. Ruddell, Indianapolis
E. S. Jones, Hammond

DR. J. WILLIAM WRIGHT, President-elect:

Doctor Black, Judge, Fellow Delegates, Fellow Workers: First I want to thank the members of the delegation from Indianapolis for nominating me for this very, very high honor. Second, I want to

thank each and every one of you members of this House of Delegates for electing me to this very, very high office. This is one of the greatest honors that a man can have in the medical profession. I will continue, as I have done in the past, to make every effort to protect and preserve the best theory and practice of medicine in the entire world for the best citizenry in the best country in all the world. I thank you.

DR. ROY V. MYERS, Treasurer: I want to thank you. Dr. Weyerbacher has served you long and well, and I hope that I may partially approach his fine record. I assure you I shall do my best.

Vote of Thanks to Dr. Weyerbacher

DR. A. M. MITCHELL: I would like to make a motion that we rise in a vote of thanks to Dr. Weyerbacher for his long, efficient, and faithful service to this association. (Motion seconded by Dr. J. T. Oliphant. Applause.)

Distinguished Guests

At this time the president introduced the following guests, each of whom briefly addressed the House:

Elmer L. Henderson, M.D., president, American Medical Association.

George F. Lull, M.D., secretary and general manager, American Medical Association.

Thomas A. Hendricks, secretary, Council on Medical Service, American Medical Association, and executive secretary emeritus, Indiana State Medical Association.

Place of 1952 Annual Session

On motion of Drs. F. S. Crockett, the House voted unanimously to hold the 1952 annual session in Indianapolis.

Elections of Councilors

Elections of councilors to replace those whose terms will expire December 31, 1950, were reported as follows:

1st District—Herman T. Combs, Evansville, re-elected.
4th District—Charles Overpeck, Greensburg.
7th District—Roy A. Geider, Indianapolis.
10th District—William H. Howard, Hammond, re-elected.
13th District—Election to be held on November 8.

Reports of Reference Committees

SECTIONS AND SECTION WORK

DR. JACK PORTER, chairman, presented the following report, which on motion of Drs. Porter, and J. T. Oliphant, was adopted as a whole:

The reports of the Committees on Scientific Exhibits, Instructional Courses, and Scientific Work were referred to your Committee on Sections and Section Work.

Your committee wishes to congratulate Dr. Clyde Culbertson and his committee on their group of scientific exhibits. As in the past, their general interest and educational value was readily apparent.

We wish to commend the work of Dr. Gordon W. Batman and Dr. Russell A. Sage, co-chairmen of the Committee on Instructional Courses, and their committee. Your committee has noted their report on page 23 of the handbook for the House of Delegates and has attended some of the courses.

Your committee wishes also to congratulate Dr. William C. Reed and his committee members for the program presented at the General Meetings. We noted and approved of their choice of more Indiana physicians as speakers than was formerly made.

Your committee has received the resolution regarding re-establishing section meetings in the Section on Ophthalmology and Otolaryngology, which was presented at the request of Dr. Dyar, section secretary. After careful consideration, your committee recommends that it not be adopted at the present time. We believe that this is a request which should be submitted to the Committee on Scientific Work. During recent years the policy of the Committee on Scientific Work has been to grant to each section the privilege of choosing a speaker for the program presented at the General Meetings.

Mr. President, I move the adoption of this report as a whole.

JACK PORTER, M.D., *Chairman*
E. B. JEWELL, M.D.
ROBERT H. RANG, M.D.
CARL HENNING, M.D.
WALTER STOUT, M.D.

RULES AND ORDER OF BUSINESS

DR. VIRGIL McCARTY, chairman, presented the following report, which was adopted, on motion of Drs. McCarty and William Karsell:

Your Reference Committee on Rules and Order of Business met and briefly considered all matters referred to them for their consideration. Since no problems were referred to our committee, and since the present rules and order of business were considered most satisfactory, no recommendations are being made.

I move the adoption of this report.

VIRGIL McCARTY, M.D., *Chairman*
F. M. FARGHER, M.D.
WILLIAM KARSELL, M.D.
M. C. TOPPING, M.D.
ROBERT D. HOWELL, M.D.

MEDICAL EDUCATION AND HOSPITALS

DR. J. E. DUDDING, chairman, presented the following report, which was adopted section by section and as a whole, on motion of Dr. Dudding, with seconds as shown:

Your reference committee has given careful study to the report of the Committee on Medical Education and Hospitals and is in general accord with all of its recommendations. Your reference committee wishes to emphasize paragraph 6 concerning the educational value of a well-organized hospital staff in presenting adequate programs. It would recommend also that the University continue

to enlarge its program of bringing postgraduate education to the smaller societies through their councilor districts and thereby reach a greater number of physicians at a time. Your committee would question the advisability of employing a full-time physician to engage in this program. (Seconded by Dr. Charles N. Combs.)

Your committee endorses the principle of establishing a loan revolving fund for needy medical students and nursing students but would disapprove the outright grant of funds to any student. The committee feels that funds should be provided to conduct an educational campaign to glamorize the nursing profession.

Your reference committee would suggest the exploration of setting up the first year curriculum for pre-nursing course in the University extension centers so as to minimize the cost of nursing education.

Finally, the medical profession at large should be reminded of its function in encouraging private funds to endow nurses training.

Your reference committee would recommend the discontinuance of the outright grant fund and a loan revolving fund be substituted for both medical and nursing students. (Seconded by Dr. Minor Miller.)

Resolution for improvement and enlarging of Indiana University School of Medicine. Your committee unanimously approves this resolution. (Seconded by Dr. Elton R. Clarke.)

Your reference committee strongly approves the resolution prepared by the Executive Committee and Council in reference to the Hess Report, as approved by the House of Delegates of the A.M.A., and recommends that the president appoint a standing committee to implement the provisions of the Hess Report. (Seconded by Dr. William C. Wright.)

Mr. Chairman, I move you that this report be accepted as a whole. (Seconded by Dr. M. B. Catlett.)

J. E. Dudding, M.D., *Chairman*
Robert K. Webster, M.D.
A. S. Giordano, M.D.
W. C. Wright, M.D.
Roy V. Myers, M.D.

PUBLIC POLICY AND LEGISLATION

DR. PAUL D. CRIMM, chairman, presented the following report, which was adopted section by section, and as a whole, on motions of Dr. Crimm, with seconds as noted:

1. The report of the Committee on Public Policy and Legislation was approved as written in the handbook. We extend our sincere thanks for their services so ably rendered. Mr. President, I move the adoption of this report. (Seconded by Dr. Harold C. Ochsner.)

2. The report of the Committee on Public Relations was approved as written in the handbook. We commend them for the excellent work they performed. Mr. President, I move the adoption of this report. (Seconded by Dr. Minor Miller.)

3. The report of the Sub-Committee on Grievances as written in the handbook was approved. Although this committee and its objectives are in its infancy, we appreciate its efforts in pioneering this field of endeavor. Mr. President, I move the adoption of this report. (Seconded by Dr. W. C. Stover.)

4. We recommend the approval of the report of the Committee on Crippled Children Service, which includes its suggestions for improving said services. We thank the members for their excellent work. Mr. President, I move its adoption. (Seconded by Dr. Will Thompson.)

5. This committee approves the report of the Committee on Maternal and Child Health, and commends it for withholding the approval of any legislative action on a bill to provide medical and hospital care for school children to cover injuries which occur in the course of school activities. We believe this is a problem of local school boards. Mr. President, I move its adoption. (Seconded by Dr. J. E. Dudding.)

6. We approve the report of the Committee on Rural Health and recommend to the House of Delegates that it be given permission to set up machinery to place the plan outlined in the handbook in operation. We recommend that at least two members of the Indiana State Medical Association be appointed by the Executive Committee of the association on all executive committees of the organization at both the state and county levels. Mr. President, I move the adoption of this report. (Seconded by Dr. Paul R. Tindall.)

7. We recommend that the A.M.A. Campaign Coordinating Committee be continued next year, in keeping with the financial position of the association, and in keeping with the political situation as it exists. Some form of action similar to this should be continued, and for that purpose the committee was of the opinion that the Council should recommend that our state dues for next year remain at $35.00. The Council approved this and asks that the House of Delegates do likewise, because in addition to the need for money to fight national health insurance, a good many members will be in the armed services, and therefore will not pay dues. Mr. President, I move the adoption of this report. (Seconded by Dr. Oran A. Province.)

8. The following is a resolution memorializing the Congress of the United States with respect to a national compulsory health insurance program:

Whereas the American people now enjoy the highest level of health, the best standards of scientific medical care and the finest medical institutions ever attained by any major country in the world; and

Whereas these accomplishments of American medicine are the results of a free profession, working under a system of free enterprise; and

WHEREAS the experience of all countries where government has assumed control of medical care has been a progressive deterioration of medical standards and medical care, to the detriment of the health of the people; *now, therefore be it*

Resolved by the members of the Indiana Legislature in eighty-seventh session assembled, a majority of the members agreeing thereto:

1. That the Legislature of the State of Indiana respectfully request the Congress of the United States to refrain from imposing upon the citizens of the nation any form of compulsory insurance, or any system of medical care designed for national bureaucratic control.

2. That Indiana Senators and Representatives now in the Congress of the United States be and are hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation.

3. That copies of this resolution be transmitted by the Clerk of this Legislature to the President of the United States, the presiding officers of the United States Senate and United States House of Representatives, and to each Senator and Congressman from Indiana.

Mr. President, I move the adoption of this resolution. (Seconded by Drs. Karl R. Ruddell and J. T. Oliphant.)

9. This committee thanks Dr. Burney for his informative report on the policies of the Indiana State Board of Health, and the same will be filed.

10. The Reference Committee on Public Policy and Legislation studied the resolution on changing the existing law on premarital blood testing, to be changed in such a manner as to permit the delivery of blood specimens directly to the laboratories for examination instead of by mail. We referred this resolution to the Indiana Association of Pathologists, and asked what their experience had been in regard to hemolyzation of specimens. The Indiana Association of Pathologists recommends to your committee that:

1. This law be amended to introduce a waiting period at the county clerk's office; and

2. That mailing of specimens and/or reports not be mandatory.

Your reference committee on Public Policy and Legislation recommends the acceptance of these recommendations. I move their adoption. (Seconded by Dr. F. M. Gastineau.)

All of these reports are respectfully submitted by your committee composed of:

PAUL D. CRIMM, M.D., *Chairman*
R. R. CALVERT, M.D.
DAVIS W. ELLIS, M.D.
A. M. MITCHELL, M.D.
HAROLD C. OCHSNER, M.D.

Mr. Chairman, I move the adoption of the entire report. (Seconded by Dr. George Daniels.)

PUBLICITY

DR. J. M. KIRTLEY, Chairman, presented the following report, which was adopted on motion of Drs. Kirtley and J. R. Doty:

The report of the Committee on Publicity was read and approved. This committee should especially be commended for its farsightedness in using the new medium of television in keeping the public informed correctly of things medical. The audio-visual instruction thus made possible is particularly desirable.

The report of the Committee on Necrology was read and unanimously approved.

The report of the Committee on State Fair, together with the supplementary report, was read and approved. The intelligent use of the State Fair as a medium of legitimate medical publicity and public instruction deserves commendation.

J. M. KIRTLEY, M.D., *Chairman*
C. C. HERZER, M.D.
RAY ELLEDGE, M.D.
ORAN A. PROVINCE, M.D.
ORVILLE A. HALL, M.D.

HYGIENE AND PUBLIC HEALTH

DR. MARVIN L. McCLAIN, chairman, presented the following report, which was adopted section by section and as a whole, on motions by Dr. McClain, with seconds as shown:

1. The report of the Committee on Industrial Health was read and approved with commendation. I move the adoption of this report. (Seconded by Dr. J. E. Dudding.)

2. The report of the Committee on Cancer was read and approved. We agree that the public educational program may be proceeding too fast compared to the professional educational program.

We also agree with the policy that every physician's office should be a cancer detection center. I move the adoption of this report. (Seconded by Dr. Carl Henning.)

3. The report of the Committee on Conservation of Vision was read and approved. I move adoption of this report. (Seconded by Dr. Will Thompson.)

4. The report of the Committee on Diabetes was read and approved. I move adoption of this report. (Seconded by Dr. A. C. Nickel.)

5. The report of the Committee on Hard of Hearing was read and approved.

We commend the Committee for pointing out again the audiometer test law. This is an obligatory law, requiring annual testing of all school children. Compliance with this law is highly desirable.

We commend highly this committee's attempt to increase all organized effort throughout the state for the conservation of hearing. I move adoption of this report. (Seconded by Dr. Claude D. Holmes.)

6. The report of the Committee on Heart Disease was read and approved. I move adoption of this report. (Seconded by Dr. A. P. Hauss.)

7. The report of the Committee on Infantile Paralysis was read and approved. I move adoption of this report. (Seconded by Dr. Elton R. Clarke.)

8. The report of the Committee on Mental Health was read and approved. We commend the commit-

tee on a great amount of work well done. I move adoption of this report. (Seconded by Dr. William H. Garner.)

9. The Report of the Committee on School Health and Physical Education. We commend this committee for its efforts to improve the teaching of health in the schools. We are anxious to have a better physical fitness program, with the children having physical examinations and follow-ups a reasonable number of times throughout their school career. However, we believe the school health program should follow closely the principles as outlined in the brochure, "Suggested School Health Policies." It is pointed out that regardless of the method used to find defects, these defects are to be corrected by the private physician.

In the supplementary report item (1) which reads as follows: "Make an effort to speed up the consolidation of schools since a good health program in the smaller schools is both difficult and unduly expensive," and item (3) "Make the state superintendent of public instruction an appointive office for at least four years and give the department sufficient funds to carry out research and surveys to give our schools the leadership they should have," seems to be out of the realm of our jurisdiction.

I move adoption of this report with deletion of items 1 and 3 in the supplemental report. (Seconded by Drs. Oliphant and Harry P. Ross.)

10. The report of the Committee on Traffic Safety is approved except for item 3. Instead, we would insert this paragraph:

"We feel that the present law requiring the reporting of epileptics has potential possibilities of doing harm to the unfortunate sufferer from epilepsy and jeopardizes the physician who reports or fails to report the cases, but we believe there should be much more study before writing a new law."

I move adoption of this report with this change. (Seconded by Dr. O. T. Scamahorn.)

11. The report of the Committee on Tuberculosis was read and approved. I move its adoption. (Seconded by Dr. J. L. Allen.)

12. The report of the Committee on Venereal Disease was read and approved. We commend the committee on noting that prenatal blood tests are not being done in many cases. I move adoption of this report. (Seconded by Dr. A. C. Nickel.)

Mr. President, I move the adoption of this report as a whole. (Seconded by Dr. O. T. Scamahorn.)

MARVIN L. MCCLAIN, M. D., *Chairman*
JOHN S. HASH, M.D.
F. R. N. CARTER, M.D.
O. H. STEWART, M.D.
O. T. SCAMAHORN, M.D.

AMENDMENTS TO CONSTITUTION AND BY-LAWS

DR. CLEON A. NAFE, chairman, presented the following report, which, on motions of Dr. Nafe, seconded by those indicated, was approved in each section and as a whole:

Your Reference Committee on Amendments to the Constitution and By-Laws had three proposals referred to it.

1. The standing Committee on Constitution and By-Laws in their report stated "Acting in accordance with the direction of the Council, we submit the following amendment to the By-Laws:

" 'That Section 2 of Chapter I—*Membership*, be amended by the addition of the following: "Provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect." ' "

Section 2 of Chapter I then would read: "Any physician who is a member in good standing of a component medical county society, and who has paid to this association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect."

Your reference committee approves of this change in the By-Laws, and I therefore move, Mr. President, that the above change in Section 2 of Chapter I be made. (Seconded by Dr. Catlett.)

Your reference committee unanimously agreed that the House of Delegates recommend to each component county society that it change its By-Laws in regard to membership to conform with this requirement. I therefore move that this recommendation be made by the House of Delegates. (Seconded by Dr. Minor Miller.)

2. The Standing Committee on Constitution and By-Laws, pursuant to instructions from the Council, submitted the recommendation that Section 12, Chapter XI, that has to do with collection of dues by the county societies for the state, be amended by the addition of the following: "In the event the county society remits a member's dues for good cause, and the secretary of a county medical society recommends in writing the remission of the state association dues of said member of the society, and shows good cause why such recommendation should be granted, the Council shall have power to remit such dues."

Your reference committee approves the above proposed addition. I, therefore, move that Section 12, Chapter XI, be so amended. (Seconded by Dr. A. S. Giordano.)

3. The following resolution, submitted by the Clark County Medical Society delegate at the Monday meeting of the House of Delegates, was referred to this committee:

"WHEREAS, It is considered desirable that the medical districts should conform to the congressional districts of the state of Indiana, and

"WHEREAS, there will be a redistricting of the state of Indiana after the 1950 census, *therefore be it*

"*Resolved,* that the Indiana State Medical Association make the necessary changes to cause these districts to conform with the congressional districts of the state of Indiana when the new districts are set up and, *be it further*

"*Resolved,* that the procedure be followed whenever new congressional districts may be formed."

Your committee discussed this proposal at length and recognizes that there is much merit in the proposal that councilor districts conform with congressional districts. It recognizes that by such arrangement a councilor and his councilor district would have a much closer liaison with their congressman than under the present arrangement, and would therefore be a more potent influence in determining the thinking of that congressman on matters that pertain to health and medical practice.

However, Article VII of the constitution, titled, "Sections and District Societies," provides for the councilor districts as follows: "The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such councilor district societies as will promote the best interest of the profession, such societies to be composed exclusively of members of component medical societies. Councilor districts shall be defined by the House of Delegates."

It was the judgment of your reference committee that there need be no change in the constitution to effect the changes requested by the foregoing resolution, if the House of Delegates desired to make those changes. Since these changes can be made by any House of Delegates, it is the recommendation of your reference committee that no action be taken on the formation of new councilor districts, until the pending congressional redistricting of Indiana be determined. I therefore move that the Clark County resolution be not approved. (Motion seconded by Dr. A. M. Mitchell.)

I move that the entire report of the Reference Committee on Constitution and By-Laws be approved. (Seconded by Dr. A. C. Nickel.)

CLEON A. NAFE, M.D., *Chairman*
A. P. HAUSS, M.D.
J. R. NASH, M.D.
G. B. WILDER, M.D.
I. E. HUCKELBERRY, M.D.

REPORTS OF OFFICERS

DR. M. E. GLOCK, chairman, presented the following report which was adopted on motion of Drs. Glock and Oran Province:

Your Reference Committee on Reports of Officers met and reviewed the addresses of the president and president-elect, and also examined the reports of the following officers and committees, all of which were approved by the reference committee:

1. Report of Executive Secretary.
2. Report of Treasurer.
3. Report of Chairman of the Council.
4. Reports of Councilors.
5. Report of the Executive Committee.
6. Report of Auditing Committee.
7. Report of the Editor of THE JOURNAL.

The president is commended for his excellent address. His term of office has been notably successful through his untiring efforts and his stimulation and coordination of his fellow officers and committees. He has endeared himself to all of us because of his friendly and unaffected performance of his duties.

The president-elect is to be complimented on his statement of policies and his clear vision of the problems affecting the medical profession. We should follow his timely advice and do all in our power to aid him in carrying out his duties in the coming year.

The committee wishes to commend the officers and committees on the excellent work they have done in the past year.

I move the adoption of this report.

M. E. GLOCK, M.D., *Chairman*
D. D. DICKSON, M.D.
RICHARD P. GOOD, M.D.
S. J. PETRONELLA, M.D.
JAMES F. REILLY, M.D.

CREDENTIALS

DR. WILLIAM E. AMY, chairman, presented the following report which was adopted on motion of Drs. Amy and A. P. Hauss:

The work of the Committee on Credentials is running very smoothly. We see no cause for any change.

WILLIAM E. AMY, M.D., *Chairman*
MILTON OMSTEAD, M.D.
CARL F. BRIGGS, M.D.
W. G. PIPPENGER, M.D.
WILLIAM DANNACHER, M.D.

MISCELLANEOUS BUSINESS

DR. B. M. MERRELL, chairman, presented the following report, which, on motions of Dr. Merrell, seconded by those indicated, was adopted in each section and as a whole:

The Reference Committee on Miscellaneous Business met, with all members present, and, after reading and discussing all material referred to it, presents the following report:

1. Report of Committee on Convention Arrangements. The Committee on Miscellaneous Business wishes to extend its sincere thanks to the Orange and Vanderburgh County Medical Societies for their efforts in making this a most successful and hospitable convention.

2. The Committee on Miscellaneous Business approves the report of the Committee of Confer-

ence of County Medical Society Officers, as printed in the handbook on page 18. (Seconded by Dr. A. W. Cavins.)

3. The Committee on Miscellaneous Business approves the plan of the Committee on Emergency Medical Service as it is given in conjunction with the written report in the handbook on Veterans Affairs and Rehabilitation, page 34. (Seconded by Dr. Cavins.)

4. The Committee on Miscellaneous Business approves the report of the Indiana A.M.A. Campaign Coordinating Committee, as written in the handbook, on page 21, with a recommendation that the present most important committee be continued at its present status and personnel. (Seconded by Dr. Glen V. Ryan.)

5. The Committee on Miscellaneous Business approves the report of the Committee on Veterans Affairs and Rehabilitation, as written in the handbook, on page 34. (Seconded by Dr. Stover.)

6. The Committee on Miscellaneous Business approves the report of the Special Committee on Disability Insurance, with the recommendation that the present special committee continue its fine work. (Seconded by Dr. J. R. Frank.)

7. The Committee on Miscellaneous Business approves the report of the Special Committee on Income Pension Plan as approved by the Council. (Seconded by Dr. Petronella.)

8. The Committee on Miscellaneous Business recommends that the state office of the Indiana State Medical Association write a form personal letter to each delinquent member, placing emphasis on the fact that without adequate membership we will lose representation in the House of Delegates of the A.M.A. (Seconded by Dr. Hauss.)

9. The Committee on Miscellaneous Business approves the resolution presented by Dr. Don Howell in recognition of Dr. A. F. Weyerbacher, treasurer of the Indiana State Medical Association, with the following recommendation: That the memento be in the form of some usable object to Dr. Weyerbacher. (Seconded by Dr. Charles N. Combs.)

Mr. President, I move the adoption of this report as a whole. (Seconded by several.)

B. M. Merrell, M.D., *Chairman*
John M. Paris, M.D.
Maurice V. Kahler, M.D.
James Burk, M.D.
H. P. Graessle, M.D.

PREPAID MEDICAL INSURANCE

DR. ELTON R. CLARKE, chairman, presented the following report:

1. The report of the Committee on Prepaid Medical and Hospital Insurance as published in the September Journal is approved, with the exception of recommendation No. 2, "That the Board of Directors of Mutual Medical Insurance, Inc., amend its by-laws (if necessary) to provide regular and more frequent meetings of the board," which we believe should be deleted. Mr. President, I move the adoption of this section of the report. (Seconded by Dr. Richard P. Good, and adopted.)

2. The supplementary report of the Committee on Prepaid Medical and Hospital Insurance as read in the House of Delegates meeting of September 25, 1950, was adopted. I move the adoption of this part of the report. (Seconded by Dr. William C. Reed.)

Discussion

DR. S. J. PETRONELLA (Lake County): Mr. President and members of the House of Delegates: Before I proceed to discuss this matter, I should like to ask if we are having under consideration the supplementary report made by Doctor Hauss, that is, the portion in regard to postponing further action on this matter. (This statement was confirmed.)

I do not wish to take too much time, but I do want to get a discussion started on this subject. I believe that this matter has been cussed and discussed sufficiently, so that a decision may be reached at this particular time. In my humble opinion, it appears to me that the majority of opinion is against postponing further consideration on this matter. There are many delegates present, I am informed, who are instructed to defeat any further consideration of this plan. Hoping to hear more from other members of the House of Delegates, I for one should like to urge each and every delegate here to vote against the acceptance of this proposal, so that The Service Plan will once and for all, at least as far as this present House of Delegates is concerned, become a dead issue. I see no need for our having to convene at a special meeting of the House of Delegates. I can see no need for the committee, which has done a wonderful job, to continue to spend more time and money on this matter, which seems to be so objectionable on the part of the members of the Indiana State Medical Association. I therefore again urge the Delegates not to accept that portion of the report. Thank you.

DR. CHARLES N. MANLEY (Dearborn-Ohio): We had a meeting last Thursday night. We unanimously adopted a resolution against any service type plan, now or later. I feel that if we are going to get into that type of thing, we might as well let the government take over now and do it for us. We won't have to worry about the details.

DR. M. E. GLOCK (Allen County): We were instructed by our society to come down here and oppose any type of service plan, now or at any later date. As I see it, the proposal to reconsider this for a period of two months, and then ask all of us to reassemble some time in December or January, to reconsider this plan is a little foolish. I think the consensus of the doctors throughout

the state is that they do not desire the service type of plan, and I don't believe that anybody is going to sell it to us in the next two months. If I understand it correctly, if we oppose this proposal, this plan will be killed, at least until another meeting of this House of Delegates. I sincerely ask your support in killing this proposal at this time.

DR. A. S. GIORDANO (St. Joseph County): You will recall that when this subject came up we spent a good deal of time in discussing service plans versus the indemnity plan, and I think the unanimity of opinion was that the indemnity plan was the only plan we should consider. We discussed this thing before we came down here.

We have heard criticisms of the indemnity plan, that some of the surgeons would increase the agreed fee and some would even double the fee. We have solved that problem by setting up a reference committee, so that when any abuses come up, where any man gets out of line with his pricing, he can be brought back into the fold by taking him aside and telling him what this is all about.

I believe we should keep on emphasizing to physicians that the present surgical plan is designed for low income groups, and for that reason the fees are kept at a minimum, and any surgeon who accepts such a plan should cooperate with the medical profession by holding to these prices. We all realize that this surgical plan should be augmented so as to cover catastrophic medical illness, as well, and for this reason our indemnity plan should be extended to these medical illnesses. At first we should stay away from minor medical illnesses, which a patient can ordinarily finance readily without resorting to insurance, in order to keep the subscription cost at the lowest possible level until sufficient experience is available to extend medical service on an insurance basis.

The committee of the St. Joseph County Medical group met and discussed this problem, and there was a unanimity of opinion that our present indemnity plan should be kept and extended.

(The motion for adoption of the supplementary report of the Committee on Prepaid Medical and Hospital Insurance was lost on voice vote.)

3. The proposed resolution suggesting changes or additions to the present indemnity plan contract of Mutual Medical Insurance Inc., was withdrawn, and so required no action by our committee.

4. The resolution based on the "Hess Committee" report was approved in principle, although recognizing the practical difficulties to be overcome. We reaffirm our adherence to the principle of retaining the practice of medicine in all its branches by the licensed physicians. Mr. Chairman, I move the adoption of this section of the report. (Seconded by Dr. M. C. Topping, and carried.)

I move the adoption of this report as a whole, with the exception of paragraph 2 which concerns the supplementary report of the Committee on Prepaid Medical and Hospital Insurance and which was disapproved. (Motion seconded by Dr. Petronella, and amended report adopted.)

ELTON R. CLARKE, M.D., *Chairman*
GERALD S. YOUNG, M.D.
A. A. THOMPSON, M.D.
WILLIAM C. REED, M.D.
GORDON A. THOMAS, M.D.

Resolutions of Appreciation

DR. A. S. GIORDANO presented the following resolution, which was adopted unanimously:

"WHEREAS no organization functions successfully for the achievement of its purposes without the thought and planning of someone who is willing to put the success of the organization above any selfish desires of his own; and

"WHEREAS, in the year just past, Dr. Claude S. Black has served this association as its president with honor and distinction and proven himself worthy to join the long list of those who have served in that office, and by their efforts and sacrifices have added luster to the medical profession as a servant of humanity;

"*Therefore, be it resolved,* that this association thank Dr. Claude S. Black for his splendid service to the medical profession of Indiana as its president, and wish for him long life and happiness, and that all his works may prosper."

THE PRESIDENT: Gentlemen, I thank you from the bottom of my heart. I never thought that I should receive such an acknowledgment. I guess I have talked myself out of a job, but I thank you and thank you again.

DR. JOHN M. PARIS presented the following resolution, which was adopted unanimously:

"WHEREAS, the splendid arrangements for the happy occasion of this 101st convention of the Indiana State Medical Association were made by the members of the Orange and the Vanderburgh County Medical Societies and the Woman's Auxiliaries; and they have gone all-out to provide for the pleasure and conveniences that have contributed so much to make this convention notable for its rich scientific, educational, and social programs;

"*Now, therefore be it resolved,* that this House of Delegates hereby expresses, to the best of its ability, its gratitude to the Orange and Vanderburgh County Societies and their Auxiliaries; that we will long cherish the memory of their thoughtfulness and hospitality, which manifested the fact that they knew we were coming, for they certainly baked a nice cake for us."

On motion of Drs. Gordon Thomas and George Daniels, the House voted to send messages of greeting and best wishes for a speedy recovery to Dr. Floyd T. Romberger of Lafayette, ex-president of the association, who is confined to the hospital, and to Dr. A. F. Weyerbacher of Indianapolis, ex-treasurer, who has been ill.

No further business appearing, on motion of Dr. George Daniels, duly seconded, the House adjourned *sine die.*

"A high percentage of cases of seasickness and carsickness can be aborted or prevented by suitable doses of dimenhydrinate (Dramamine)."

—Council on Pharmacy and Chemistry, New and Nonofficial Remedies, J.A.M.A. *143*:815 (July 1) 1950.

DRAMAMINE® Brand of Dimenhydrinate—for the prevention or treatment of motion sickness—is supplied in 50 mg. tablets and in liquid form.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

EXECUTIVE COMMITTEE

August 27, 1950.

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Guests: D. C. Barrett, M.D., director, Bureau of Local Health Administration, State Board of Health; George M Brother, M.D., director, Bureau of Preventive Medicine, State Board of Health; John D. Van Nuys, M.D., dean, Indiana University School of Medicine.

Membership Report

Number of members, August 24, 1950	3,618*
Number of members, August 24, 1949	3,702
Loss over last year	84
Number of members December 31, 1949	3,758

* Includes 21 in military service (gratis)
139 $10 members (residents and interns)
209 senior members

Statements of receipts and expenditures for July for the association and THE JOURNAL were approved.

1950 Annual Session, French Lick, September 25, 26 and 27, 1950

Playing cards for Woman's Auxiliary. On motion of Drs. Ellison and Clark, authority was given to purchase playing cards for use of the Woman's Auxiliary.

Reserved tables at banquet for past presidents and councilors and their wives. On motion of Drs. Clark and Black, Dr. Augustus P. Hauss was selected to handle past presidents' and councilors' table reservations for the banquet.

The committee decided that the association will pay 25c per person tip for the Executive Committee dinner, Council luncheon, House of Delegates luncheon, stag dinner, women's dinner, women's luncheon, and the annual banquet, on motion of Drs. Clark and Ellison. Other organizations holding breakfast, luncheon or dinner meetings are to be notified that they are to be responsible for tips at each of their events. (After George Z. Davis, catering manager, refused to accept a 25c per person tip for the annual dinner, the committee voted by mail to place all tipping on an individual basis.)

Legislative Matters

National

Shearon Legislative Service. An additional contribution of $25.00 to Marjorie Shearon, legislative analyst, was voted, on motion of Drs. Clark and Ellison.

After Dean John D. Van Nuys discussed his wish to increase the enrollment in Indiana University School of Medicine from 150 to 160 freshmen, motion was made by Drs. Clark and Ellison that the Executive Committee recommend to the Council and the House of Delegates that the association request the 1951 legislature to appropriate a sufficient amount to enable the medical school to increase its enrollment sufficiently to meet the physician needs of the state.

Local

On motion of Drs. Clark and Black, the executive secretary was instructed to write a letter to the adjutant of the Paul Coble Post, expressing the committee's thanks for the excellent work of the Post in defeating the chiropractic resolution before the recent American Legion state convention.

Dr. Donald Wood was appointed to serve as the state medical association's representative on the Advisory Committee for Codification of the Indiana Pharmacy Law of the Indiana Pharmaceutical Association, on motion of Drs. Black and Clark.

Indiana A.M.A. Campaign Coordinating Committee

A check for $75.00 from the Indiana State Dental Association to pay its share of the expense of meetings with the A.M.A. Campaign Coordinating Committee was accepted and ordered placed in the campaign fund.

Organization Matters

Report by Dr. Glen Ward Lee, chairman of the Committee on Civilian Emergency Medical Defense, outlining the civilian defense plan, was read by the executive secretary.

The president announced the appointment of Dr. C. J. Clark as chairman of the Indiana Military Manpower Committee. Doctor Clark was authorized to select six other physicians to serve on the committee.

On motion of Drs. Clark and Ellison, the committee accepted the invitation of Col. E. W. Billick, Medical Corps Army Surgeon, Headquarters Fifth Army, to participate in the selecting of physicians who may be called for military service. The committee designated twenty physicians from a list of eighty names submitted by the chief of the Indiana Military District who should be deferred in filling the first quota.

Blood typing at Indiana State Fair. On motion of Drs. Clark and Ellison, the committee voted to participate in blood grouping demonstration at the State Fair in cooperation with the Indiana Department of Civilian Defense, Indiana University Medical Center, State Board of Health, Red Cross and Indiana Society of Medical Technicians.

Emergency blood banks. The committee decided to explore the emergency blood bank situation in cooperation with the Red Cross, and Doctor Black appointed the following committee to serve in this capacity: Clyde G. Culbertson, J. L. Arbogast, George M. Brother, Indianapolis; A. S. Giordano,

more physicians are satisfied

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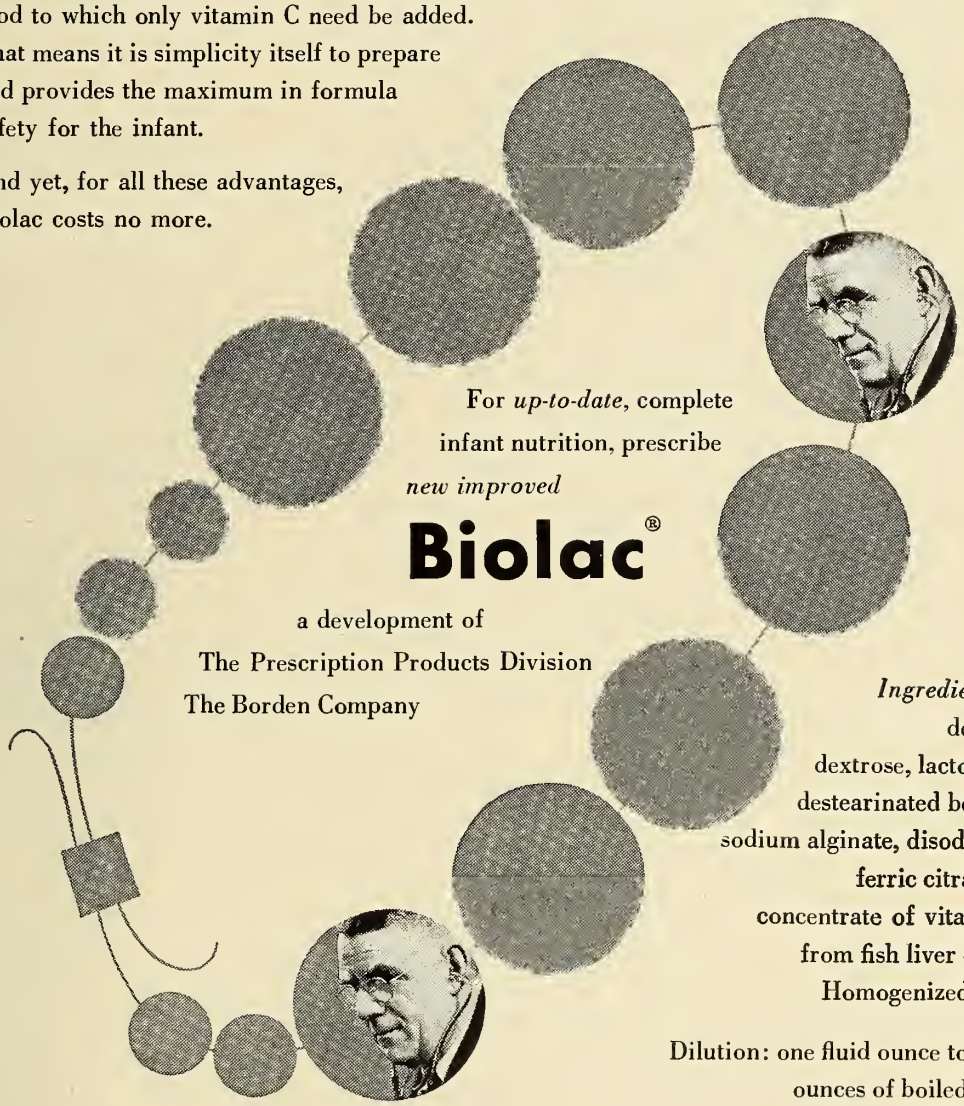

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South Bend, and A. W. Ratcliffe, Evansville. This action was taken following discussion by Doctor Brother, assistant state health administrator. Doctor Culbertson is to serve as chairman.

On motion of Drs. Clark and Ellison, the committee approved the proposed $300,000 district health clinic to be operated by Indiana University at the Indiana University Medical Center as a center where students of the I. U. School of Medicine can receive training in public health. This action was taken after a discussion of the project by Dr. John D. VanNuys.

Proposed service contract. After the chairman of the Executive Committee presented the service contract proposed by the directors of Mutual Medical Insurance, Inc., the committee deferred action on the subject until its next meeting, on motion of Drs. Clark and Ellison.

The editor of THE JOURNAL and the field secretary were designated as delegates from the association to the Indiana State Conference on Social Work in Indianapolis November 1 to 4, 1950.

Method of carrying out recommendations of Committee to Study Training of Girls to Do Simple Laboratory Procedures. The following recommendations made by this committee were approved by the Council at its meeting on July 16, 1950:

1. That the Indiana State Medical Association ask the legislature, at its next session, to make funds available to increase facilities at Indiana University for training of fully qualified laboratory workers. (Referred by the Executive Committee to the Committee on Public Policy and Legislation.)

2. That the Indiana State Medical Association formulate plans to facilitate recruitment and placement of prospective student medical laboratory workers in approved training schools, and that more hospitals be asked to establish approved schools for the training of medical laboratory workers. (Referred by Executive Committee to the Committee on Medical Education and Hospitals.)

3. That the Council on Medical Education and Hospitals of the American Medical Association be requested to call a conference of all interested organizations and agencies and that these agencies be asked to increase the facilities for training qualified medical laboratory workers, with the objective of increasing the number of these workers to fill the great national needs. (Referred by Executive Committee to the Committee on Medical Education and Hospitals.)

4. That the Council on Medical Education and Hospitals of the American Medical Association be further requested to make adequate provision for immediately supplying laboratory workers for medical practitioners' offices, and that this be given the most urgent attention. (Referred by Executive Committee to the Committee on Medical Education and Hospitals.)

5. That the Executive Committee of the Indiana State Medical Association survey the present use of medical laboratory workers in physicians' offices. (The chairman of the Executive Committee and the executive secretary are to prepare a questionnaire to be sent to physicians in the October ISMA News Flashes.)

The above action was incorporated in a motion by Drs. Clark and Black.

A resolution adopted by the Johnson County Medical Society relating to the drafting of physicians for military service was read by the chairman, and accepted, and placed on file, on motion of Drs. Black and Clark.

Future Meetings

On motion of Drs. Clark and Ellison, the president and executive secretary were directed to attend the meeting on the A.M.A. Clinical Session program at Cleveland on September 20.

On motion of Drs. Clark and Ellison, the executive secretary was directed to present the paper on the Indiana Inter-Professional Health Council at the A.M.A. Council on Medical Service Health Council Conference in Detroit on October 1.

On motion of Drs. Clark and Black, the field secretary was directed to attend the Board of Directors meeting of the Indiana State Chamber of Commerce at French Lick, September 29 to October 1, 1950.

The executive secretary was directed to accept the invitation to be a delegate to the Midcentury White House Conference for Children and Youth in Washington, D.C., on December 3 to 8, 1950, on motion of Drs. Clark and Ellison. The field secretary is to attend the Clinical Session of the A.M.A. in Cleveland, which falls on the same dates.

The Journal

Total advertising in July issue	$2,564.80
Total advertising in August issue	1,943.07

1951 roster. On motion of Drs. Clark and Black, the roster published in the July, 1951 JOURNAL is to contain the names of all paid-up members as of December 31, 1950, as well as all new members up to the time of publication.

On motion of Drs. Clark and Black, action on the request of Eli Lilly and Company that half of the cover page of THE JOURNAL be sold to it for advertising space was postponed until the next meeting.

There being no further business, the Executive Committee adjourned to meet again on Sunday, September 24, 1950, at 6:30 p.m., at the French Lick Springs Hotel, French Lick, Indiana.

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EXECUTIVE COMMITTEE

September 24, 1950.

Roll call showed the following present: C. J. Clark, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D.; W. U. Kennedy, M.D.; Roy V. Myers, M.D., assistant treasurer.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

Guest: F. H. Neukamp, M.D., Fayette-Franklin County Medical Society.

On motion of Drs. Ellison and Clark, Dr. Black was selected to preside in the absence of the chairman.

Membership Report

Number of members September 20, 1950	3,625*
Number of members September 20, 1949	3,711
Loss over last year	86
Number of members December 31, 1950	3,758

*Includes 21 in military service (gratis)
139 $10 members (residents and interns)
210 senior members

Statements of receipts and expenditures for August for the association and THE JOURNAL were approved.

1950 Annual Session, French Lick, September 25, 26 and 27, 1950

On motion of Drs. Clark and Kennedy, the committee authorized paying the hotel expenses of wives of out-of-state speakers.

On motion of Drs. Kennedy and Clark, the prepared addresses of the president and president-elect were approved.

Dr. George R. Daniels, of Marion, past president, was selected to give the response for the Fifty-Year Club members, on motion of Drs. Clark and Kennedy.

Indiana A.M.A. Campaign Coordinating Committee

The executive secretary read a letter from Whitaker and Baxter commending the association on the excellency of the advertising being run in Indiana newspapers.

Organization Matters

On motion of Drs. Ellison and Clark, the committee decided against taking action on the service type contract proposed by the Board of Directors of Mutual Medical Insurance, Inc., because the matter is coming before the House of Delegates.

A letter from Dr. Frank Forry, Professor of Pathology, Indiana University School of Medicine, calling attention to a request of the House of Delegates of the American Medical Association that a committee be appointed to study the coroner's system law, was referred to the Committee on Public Policy and Legislation, on motion of Drs. Clark and Kennedy.

Two resolutions from the Indiana Roentgen Society having to do with civilian defense were referred to Dr. Glen Ward Lee, chairman of the Committee on Civilian Defense.

Survey of laboratory workers. The executive secretary reported that the Indiana Association of Pathologists had asked permission to reword the questionnaire which is to be mailed to all members of the Indiana State Medical Association. Permission granted by consent.

Dr. F. H. Neukamp, of Connersville, of the Fayette-Franklin County Medical Society, asked for the state association's assistance in defeating a referendum in Fayette county for a full-time health department. On motion of Drs. Ellison and Clark, the State Board of Health is to be asked to try to get other counties interested in joining with Fayette county in creating a public health district, and before the State Board of Health takes any steps to promote the establishment of a full-time health department in any county, the county medical society is to be contacted.

On motion of Drs. Clark and Kennedy, the attorney for the association must obtain permission from the county medical society before he speaks before any group within the county on a subject allied with the medical profession.

The Journal

Total advertising in August issue	$1,943.07
Total advertising in September issue	2,372.87

The request of Eli Lilly and Company for half of the front cover of THE JOURNAL for advertising space was referred to the Editorial Board for an opinion.

The executive secretary reported that Hord's Sanitarium was closing and it would not be necessary to inspect it regarding its ethical status as a JOURNAL advertiser.

There being no further business, the Executive Committee adjourned.

COMMITTEE ON PUBLICITY

Present: Marlow W. Manion, M.D., chairman; James O. Ritchey, M.D.; Homer G. Hamer, M.D.; James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of September 11, 1950—"Beginning Pupils"
Week of September 18, 1950—"Athlete's Foot"
Week of September 25, 1950—"Good Posture"
Week of October 2, 1950—"Value of Food"

The radio series selected to follow the present one which expires September 16, 1950, was "Guardians of Your Health."

The secretary reported that he had been informed by the Bureau of Health Education of the A.M.A. that a series of twelve television scripts would be available the latter part of October. The scripts are for producing live shows at the local level and are designed so that even the smallest county society can use them. The use of these will be discussed further when the scripts are available.

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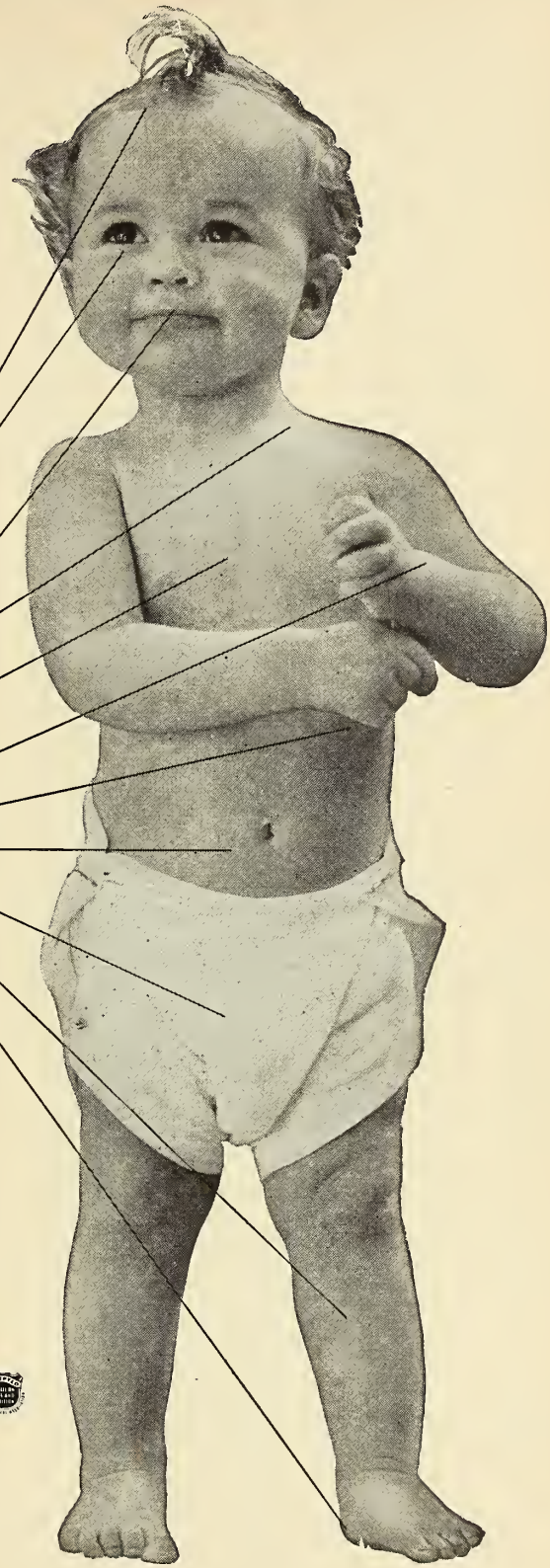

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COMMITTEE ON PUBLICITY

September 8, 1950

Present: Marlow W. Manion, M.D., chairman; Homer G. Hamer, M.D.; Ray E. Smith, executive secretary and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of October 9, 1950—"Immunization Program"
Week of October 16, 1950—"Gout"
Week of October 23, 1950—"When Sickness Threatens"
Week of October 30, 1950—"Diabetes"

The following general news releases were approved:

Medical School Scholarships
Blood Pressure Readings at Indiana State Fair
First General Story on State Meeting
Awarding of four Nursing School Scholarships
Out-of-State Speakers at State Meeting.

The committee directed the secretary to investigate the possibility and costs of producing pamphlets on timely subjects for distribution to the public through physicians offices. The first to be investigated is one on "What to do if the Atom Bomb Strikes."

COUNCILOR DISTRICT MEETINGS

TENTH COUNCILOR DISTRICT

Members of the Tenth Councilor District held a meeting in Whiting on September 12. Dr. Andrew C. Ivy, vice-president of the University of Illinois, and chairman of the Civil Defense Committee of Chicago, outlined the plan for the care of atomic explosion victims. A copy of the outline of the program was furnished to each member. Films furnished by the Fifth Army on the subject of the medical aspects of atomic bombing were also shown.

Election of officers resulted in the re-election of Dr. William H. Howard, of Hammond, as Councilor; Dr. Frank G. Sink, of Remington, president; and Dr. H. E. English, of Rensselaer, secretary.

ELEVENTH COUNCILOR DISTRICT

The Huntington County Medical Society was host for the eighty-fourth semi-annual meeting of the Eleventh Councilor District. The meeting, held Wednesday, September 20, at the Hotel LaFontaine, in Huntington, was attended by fifty-three physicians and their wives.

The afternoon scientific program featured a color movie by R. Morton Bolman, M.S., M.D., Fort Wayne, who discussed "Vagotomy in Treatment of Peptic Ulcer."

Richard S. Griffith, M.D., of the Eli Lilly Research Medical Department, presented a paper on "Hypertension."

Closing the scientific program was a paper on "Psychiatry" by Harry C. Dunstone, M.D., Fort Wayne.

During the afternoon business session, Peru was selected as the site for the May meeting.

In making his report, Elton R. Clarke, M.D., Kokomo, Councilor, discussed the proposal of Mutual Medical Insurance, Inc., to seek the approval of the profession to the addition of a service medical care plan to their present indemnity program.

James A. Waggener, field secretary, spoke briefly on association matters.

During the afternoon the wives were entertained with a musical program and a social hour. Miss Sally Butler, past president of the International Business and Professional Women's Clubs, spoke on her experiences during her recent trips to England.

Dinner was served in the main dining room of the hotel, with Mr. Leonard Harsh, magician, of Fort Wayne, entertaining the group. J. B. Bennett, M.D., president of the Huntington County Medical Society, presided during the evening.

LOCAL SOCIETY REPORTS

Clay County Medical Society members held a meeting in Brazil on September 19. Seven members were present.

Greene County Medical Society members held a meeting at Freeman Greene County Hospital, in Linton, on September 14. This was a business meeting, and fourteen members were present.

Huntington County Medical Society members held a meeting on September 5 in Huntington. Eighteen members were present to hear Drs. Thomas James, Jr., and Harold S. Brubaker, both of Huntington, speak on "Early Diagnosis of Cancer of the Breast."

Madison County Medical Society members held a meeting at the Anderson Country Club on September 18. Dr. J. E. Tether, Jr., assistant professor of Medicine at the Indiana University Medical Center, presented a paper on "Myasthenia Gravis." Sixty-three members and guests were present.

Sullivan County Medical Society members met at the Sullivan Hotel in Sulivan on August 10. Seventeen members were present. Dr. M. H. Bedwell, of Sullivan, showed color movies of Yellowstone National Park.

Vanderburgh County Medical Society members held a meeting in Evansville on September 12 as guests of the Boehne Tuberculosis Hospital board of managers. Dr. Paul Crimm, director of the hospital, presented a paper on "The Importance of Surgical Drainage in Pulmonary Infections."

Another meeting was held on October 10 at the Hotel McCurdy, in Evansville when Dr. H. J. Erwin, acting director of psychiatry at the Homer G. Phillips Hospital, St. Louis, was the guest speaker. His subject was "The Relation of Psychiatry to the Practice of Medicine."

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—AUGUST, 1950

Disease	Aug. 1950	July 1950	June 1950	Aug. 1949	Aug. 1948
Brucellosis	4	4	6	5	5
Chickenpox	8	33	131	11	5
Diphtheria	9	6	4	39	11
Encephalitis	2	1	4	3	2
Impetigo	1	0	0	0	3
Influenza	1	0	0	37	2
Measles	17	282	1167	39	25
Meningitis,					
Unclassified	1	1	1	2	3
Influenzal	1	1	2	0	1
Pneumococcal	1	1	0	1	0
Tubercular	2	0	0	0	0
Mumps	9	16	74	14	27
Pneumonia	20	25	25	38	10
Poliomyelitis	88	23	5	350	71
Rabies in Animals	25	60	62	47	60
Rheumatic Fever	1	1	0	1	1
Rocky Mountain					
Spotted Fever	1	3	3	1	2
Rubella	3	1	39	2	4
Scarlet Fever	20	21	47	20	33
Septic Sore Throat	2	0	0	30	1
Tetanus	1	0	0	0	2
Tinea Capitis	1	2	3	0	1
Tuberculosis,					
Pulmonary	142	189	174	168	195
Other Forms	12	13	15	15	13
Tularemia	4	0	0	0	1
Typhoid Fever	16	1	4	4	5
Whooping Cough	90	131	137	66	43

MONTHLY REPORT—SEPTEMBER, 1950

Disease	Sept. 1950	Aug. 1950	July 1950	Sept. 1949	Sept. 1948
Brucellosis	9	4	4	7	5
Chickenpox	21	8	33	8	19
Diphtheria	8	9	6	55	13
Dysentery, Bacillary	1	0	0	4	0
Erysipelas	2	0	0	1	2
Impetigo	2	1	0	10	6
Influenza	3	1	0	4	16
Measles	19	17	282	24	9
Meningitis,					
Unclassified	3	1	1	1	3
Influenzal	1	1	1	0	1
Mumps	21	9	16	9	21
Paratyphoid fever	2	0	1	1	0
Pneumonia	18	20	25	19	29
Poliomyelitis	175	88	23	238	136
Rabies in animals	31	25	60	17	31
Rheumatic fever	3	1	1	1	1
Rubella	14	3	1	0	8
Scarlet fever	29	20	21	32	49
Tetanus	4	1	0	2	1
Tinea capitis	6	2	1	5	2
Tuberculosis,					
Pulmonary	150	142	189	130	237
Other forms	12	12	13	18	20
Tularemia	3	4	0	1	0
Typhoid fever	4	16	1	3	10
Whooping cough	123	90	131	73	56
Encephalitis	2	2	1	5	4

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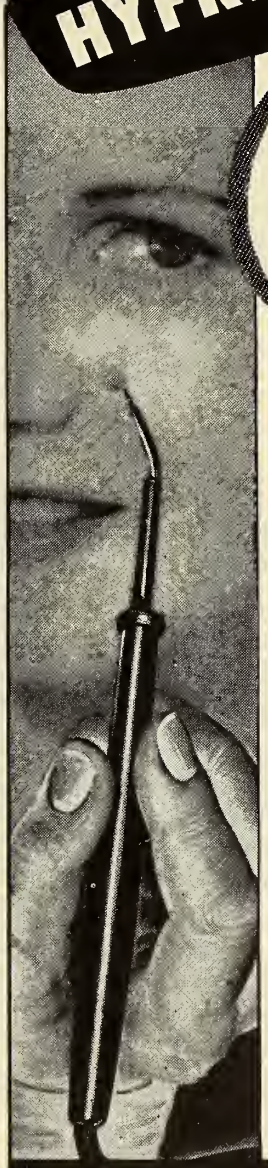

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

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ENCEPHALOMYELITIS DUE TO PASTEUR TREATMENT

Report of a Fatal Case With a Review of the Literature†

CHARLES FISCH, M.D.* AND DONALD E. WOOD, M.D.‡

INDIANAPOLIS

INTRODUCTION—In 1880 Pasteur began the epoch-making studies which five years later culminated in the use of antirabies vaccine in the treatment of rabies. His studies were enhanced by finding the infectious agent of rabies in the brains of individuals dying as a result of contracting this disease. He was able to transmit this disease, which was later proven to be due to a virus, through a series of rabbits' brains with a progressively decreasing incubation period. The incubation period finally became fixed at seven days and the virus exhibiting this incubation period became known as the fixed virus.[1] (In contradistinction, the virus harbored by rabid animals is known as the street virus.) The fixed virus was then attenuated by drying the spinal cord in jars in the presence of potassium hydroxide. In the succeeding years various other agents, namely, glycerin, phenol, formalin, chloroform, ether, and heat, were used in the process of attenuating the rabies virus. At present two main types of antirabic vaccine are in use, one containing the living virus and the other containing the dead or the attenuated virus.

INCIDENCE OF REACTIONS — Since 1885, when Pasteur first introduced the vaccine in the treatment of rabies, sporadic cases of paralysis were reported as being due to this form of therapy. Remlinger[2] and associates found 329 instances of treatment paralysis in a series of 1,164,264 patients treated for an incidence of 1:3500 (0.28 percent). Simon[3] encountered 100 cases in a series of 217,744 treated for an incidence of 1:2200 (.045 percent). In this country Sellers[4] found seven cases of treatment paralysis among about 50,000 patients treated for an incidence of 1:7000 (.014 percent).

ETIOLOGY — In a review of the literature dealing with antirabies treatment paralysis one encounters many conflicting opinions as to the etiology of this complication. At first it was assumed that the reaction represented actual rabies, the clinical course of which was modified

† Sponsored by the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are a result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

* Resident in Medicine, Veterans Administration Hospital. Present address: Indianapolis General Hospital.

‡ Consultant in Medicine, Veterans Administration Hospital.

by the vaccine. However, in 1898, Tonin[5] recorded a case of paralysis occurring in an individual bitten by a dog, which was later proven to be free of rabies. This observation by Tonin, coupled with subsequent findings that a similar reaction can be produced by repeated injections of normal brain tissue,[4] proved that postvaccinal paralysis is entirely independent of the rabies virus. We may mention in passing some other theories offered as an explanation of the treatment paralysis. One of the theories hypothecates that the reactions are due to the fixed virus present in the vaccine, another that the symptoms are produced by an obscure neurotropic virus present in the rabbit's spinal cord, and still another proposes that the postvaccinal paralysis is a manifestation of anaphylactic reaction due to the vaccine. Many others believe that the reaction is due to the foreign protein introduced during the process of immunization. This last idea is supported by the clinical observation that practically every biological product, serum or vaccine, has at one time or another been responsible for the production of a clinical picture closely resembling treatment paralysis. Grinker,[6] finding a remarkable similarity in the pathological and clinical manifestations of encephalomyelitis secondary to the antismallpox and antirabies vaccination, suggested that the "postvaccinal encephalitis may be due to some unknown, latent virus harbored in the body of the vaccinated person and stimulated to activity by the vaccination."

It is true that all the above theories and many others have their supporters, but the prevailing opinion of the workers interested in this problem is that the clinical and pathological alterations are due to an allergic reaction to the rabbit brain tissue. This theory is further supported by the studies of Rivers and Schwentker,[7] who showed that the brain of a rabbit may function as an antigen which is organ-specific rather than species-specific, and that the clinical and pathological picture seen in the postvaccinal paralysis can be reproduced in animals by repeated injections of normal brain tissues from the same or a different species of animal. Kabat[8] and his co-workers have gone a step further and produced acute disseminated encephalomyelitis in monkeys by injection of their own brain, removed surgically and incorporated with adjuvants. Horack,[5] studying a series of 16 individuals with severe postvaccinal reactions, found a positive individual and/or familial history of allergy in 87.5 percent, as compared with only 33 percent, in a control group composed of 45 individuals who received the vaccine but developed no untoward effects. In the seven instances of treatment paralysis encountered by Sellers, five of the seven have been subjected to the Pasteur treatment in the past. At present it appears that the allergic theory of treatment paralysis associated with antirabies vaccination is based on rather sound experimental and clinical observations.

PATHOLOGY — The pathological picture associated with antirabies treatment paralysis is well-defined.[6, 9, 10] Grossly, when there is involvement of the meninges, the latter are edematous and hyperemic with occasional exudate being present over the pia. The involved areas of the spinal cord have a grayish-pink appearance and show varying degrees of softening accompanied by edema. Petechial hemorrhages may be present. These changes are usually most common in the dorsolumbar portion of the spinal cord and medulla, and are less commonly found in the encephalon. Microscopically, one finds varying degrees of perivascular lymphocytic infiltration at times associated with plasma cell infiltration. There are zones of demyelinization involving the brain and the brain stem. Hemorrhagic areas and destruction of axis cylinders and the large ganglion cells of the cord may also be noted. There is little or no evidence of reparative process.

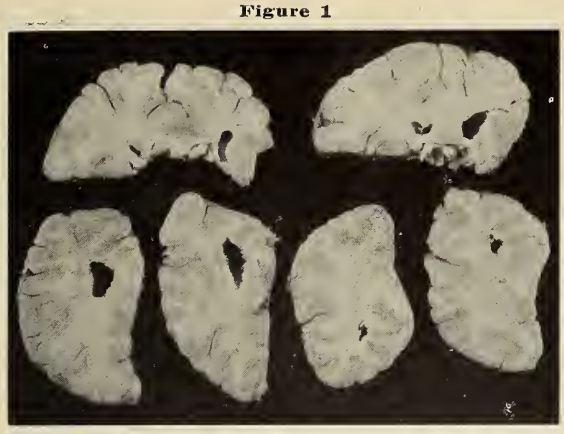
CLINICAL MANIFESTATIONS—Clinically, the manifestations of antirabies treatment reaction fall into two general groups: One seen in patients in whom there is involvement of the central nervous system, and the other encountered in individuals who show no abnormalities referable to the nervous system. The latter may manifest itself by redness, swelling, tenderness and itching at the site of injection. The patient may also exhibit systemic reaction such as fever, general malaise, urticarial rashes, swelling of joints, headache, nausea and vomiting. It is the headache, nausea and vomiting which are usually the prodromal symptoms of a subsequently developing encephalomyelitis. The picture of nervous system disorder may vary from a simple neuritis to a profound encephalomyelitis. Generally, three clinical groups of such reactions are recognized:

(1) Isolated nerve paralysis: The symptoms are usually referable to the facial nerve and there may be an associated elevation of the body temperature. This form of reaction is rare but when it occurs it contraindicates any further use of the vaccine, regardless of severity of exposure.[4]

(2) Dorsolumbar myelitis: This syndrome usually begins after the twelfth or fourteenth day of treatment. It is characterized by fever, numbness, and tingling of the extremities, sphincter disturbances and progressive paralysis of the lower extremities. Recovery is a rule in this group.

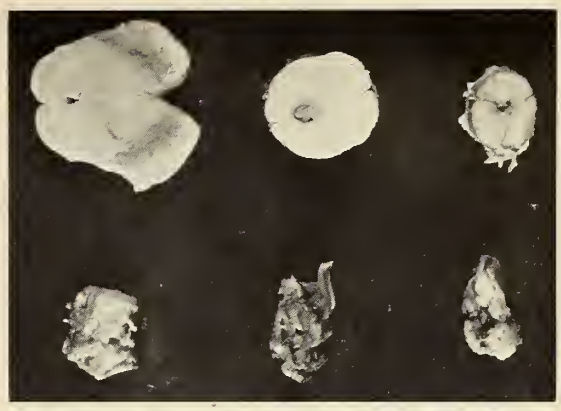
(3) Paralysis of the Landry type: This symptom complex is ushered in by severe systemic symptoms, nausea, vomiting, headache, fever, incontinence of urine and paralysis of lower extremities. The paralysis may ascend to involve the bulbar nuclei and death may ensue. The mortality rate in this group ranges from 30 to

Figure 1



Sections through various levels of the brain, showing numerous petechial hemorrhages.

Figure 2



Sections through various levels of the spinal cord and medulla, showing complete disintegration of the cord and loss of normal landmarks of medulla.

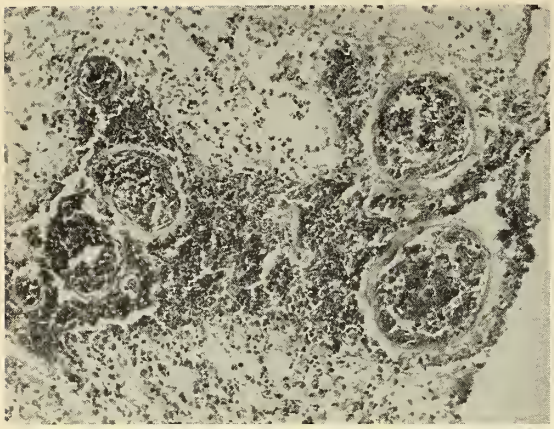
50 percent.[11] Some recover completely, others are left with varying degrees of paralysis.

Remlinger,[2] in analyzing 243 instances of reaction to antirabies vaccination, found the symptomatology to be distributed as follows:

Severe paraplegia with bladder and rectum symptoms	68
Landry's ascending paralysis	39
Paresis of both lower limbs with bladder retention	33
Unilateral paralysis of facial nerve	31
Paresis of lower limbs with bladder symptoms	21
Paralysis of facial nerve, type not stated	22
Bilateral facial nerve paralysis	5
Paralysis of facial and oculomoter nerves	4
Simple paresis of bladder	9
Miscellaneous neuritis	11

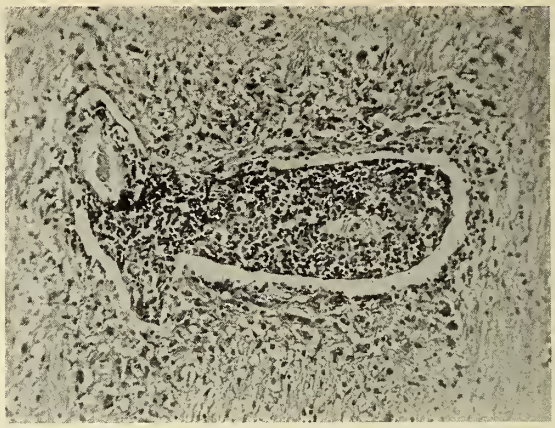
PREVENTION OF TREATMENT PARALYSIS: We are all cognizant of the fact that it is impossible to eliminate entirely the complications associated with the Pasteur treatment. However, even the smallest reduction in this incidence should be considered as a step forward. It is with this thought in mind that we present some of the following ideas and facts. Horack,[5] after finding a high incidence of allergy in the individuals developing treatment paralysis, offers the suggestion that patients who are to receive the antirabies treatment be skin tested and, if found sensitive, be desensitized. He also states that if, during the course of treatment, they acquire sensitivity to the inocula, the treatment should be stopped and process of desensitization begun. Sellers[4, 11] points out that in his group of seven cases of treatment paralysis there were four deaths. Out of the seven only two were treated because they were actually bitten by rabid dogs, the remaining five were persons only remotely exposed and were treated mainly to allay undue apprehension. Of these five, three died. As noted before, five of the seven had previously received antirabies treatment. Sellers also analyzed a series of 32 deaths due to rabies, which occurred in the 50,000 cases treated, and found that: (1) nineteen (60 percent) occurred in persons bitten more or less severely on the face. In no instance did rabies follow development of superficial face wounds. The death rate per 1,000 treated for face bites was 7.9 percent. (2) Eleven (34 percent) deaths occurred in patients following bites on hands and arms. The death rate per 1,000 treated for hand and arm bites was 0.5 percent. (3) One death (3 percent) followed bites of lower extremities. Death rate per 1,000 treated for bites of lower extremities was 0.1 percent. (4) One death followed bites of body; for a death rate per 1,000 treated for bites of body of 0.1 percent. He believes that the number of people seeking advice for remote exposures by far exceeds the number of those who actually receive treatment, and yet in his knowledge ". . . in no instance has rabies developed in any of these." He suggests that for any exposures other than bites, or where the saliva of rabid animals comes into contact with broken skin, the physician should refuse treatment or strongly advise against it. Sellers further adds that in persons who received previous antirabies treatment and "regardless of the elapsing interval since the last treatment, reimmunization should be advised for borderline exposures, such as superficial wounds of the extremities. Retreatment should be limited in any case to a short booster series of five or six injections." In summary, he states, "It is not hydrophobia but rather rabiphobia which constitutes the major and most troublesome problem to the practicing physician and health officers. The administration of antirabies vaccine to persons actually bitten or scratched by the teeth of known or supposed rabid animals is a relatively simple and justifiable procedure regardless of the outcome, in that the danger of the disease is far greater and more

Figure 3



Photomicrograph of a central area of the medulla, showing blood vessels and surrounding area of hemorrhage.

Figure 4



Photomicrograph of a blood vessel with marked perivascular infiltration (confined primarily to the Virchow-Robin space).

serious than any ill effects from the vaccine, but for exposures other than actual bites, the danger of treatment complications far exceeds that of either rabies or rabiphobia."*

We are all aware of the fact that there are many unsettled questions as to the relative merit of one type of vaccine as compared with another; many even doubt the value of the Pasteur treatment per se as a protecting measure against the development of rabies. Webster,[12] in his monograph on rabies, states, "Of less practical but of no little theoretical importance are the additional facts that in the absence of treatment the chances of exposed persons to contracting rabies are unknown; that, according to statistics in man, one vaccine is no more effective than another; that a fourteen-day or longer delay in commencing treatment is no handicap; and finally, that controlled experiments have yielded no clear-cut evidence that vaccine treatment reduces the mortality from rabies."

However stimulating the above thoughts may be, it is still true that the majority of immunologists believe that the Pasteur treatment is valuable and the practitioner would not be justified in denying treatment to those who really need it. On the other hand, anyone treating a patient with antirabies vaccine must be aware of its dangers, indications and contraindications.

The following case of encephalomyelitis resulting from Pasteur treatment was thought worth-while reporting because of its relative rarity and because of the profound changes affecting the central nervous system encountered at time of necropsy.

CASE REPORT

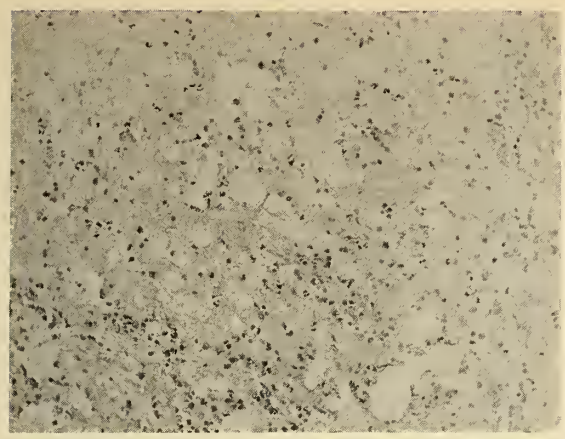
The patient, a twenty-six-year-old white male, was admitted to the Veterans Administration Hospital in Indianapolis on June 8, 1948, because of paralysis of all extremities, intercostal and abdominal muscles. According to the available history, on or about May 21, 1948, the patient was bitten about the right arm by a dog which was subsequently proven to be rabid. The Pasteur treatment was started on May 21. Each injection was followed by a severe local reaction and elevation of temperature, the latter lasting about eight hours. The full course of treatment was finished on June 3. During that night the patient developed a high temperature, severe headache and backache. On the morning of June 4, he was found to be paralyzed from the waist down. The temperature was 107° F. The paralysis ascended rapidly, and on June 7 there was complete paralysis of the intercostal muscles. During a period of twenty-four hours prior to admission to this hospital the patient was confused and experienced hallucinatory periods.

Examination at the time of admission disclosed a well-developed, well-nourished, adult, white male who was acutely and seriously ill. He was disoriented as to time, place and person. Temperature 100° F. Pulse 64. Respirations 18 per minute. Blood pressure 128 mm. of Hg. systolic and 50 mm. of Hg. diastolic. Pupils were round and equal and reacted to light. Respirations were entirely diaphragmatic in character. Percussion note was normal. Tactile fremitus disclosed no alterations. Coarse rhonchi were heard throughout entire chest. The heart was normal as to size, rate, rhythm and sounds. The urinary bladder was distended. Neurological examination disclosed stiffness of the neck with pains on flexion, the cranial nerves were intact. Kernig's sign was positive bilaterally. There was flaccid paralysis of both arms, intercostal and abdominal muscles, and both lower extremities. Examination of the sensory response disclosed spotty anesthesia levelling fairly well at the midthoracic region. There was loss of position and pain sense. Superficial and deep reflexes were absent. No pathological reflexes were present.

Laboratory studies disclosed a red blood cell count of 3,900,000 with 11.5 grams of hemoglobin. The white blood cell count was 9,900 with a normal differential count. Spinal fluid examination revealed the following: Cell count 800 with 90 percent polymorphonuclears and 10 percent lymphocytes, sugar was 60 milligrams percent, total protein 120 milligrams percent, Pandy's test was 2 plus. Aerobic and anaerobic culture disclosed no growth. Mouse inoculation tests were done at the Army Medical School and the Indiana State Board of Health, and in each instance the test was reported as being negative for evidence of rabies. Spinal puncture performed at time of admission disclosed a pressure of

* The two articles by Sellers are highly recommended to the reader for we are convinced that the author's practical approach to the subject of antirabies treatment will add immeasurably to the crystallization of one's thoughts on the rather acute and pressing problem of the Pasteur treatment.

Figure 5



Photomicrograph of a section through the spinal cord disclosing necrosis and complete disintegration of the cord substance.

380 millimeters of water. Following withdrawal of 12 cubic centimeters the pressure fell to 120 millimeters of water. The patient was kept in a respirator with no apparent improvement being noted. On June 11, while being prepared for a spinal puncture and before the procedure was started, the patient suddenly became cyanotic and expired.

AUTOPSY FINDINGS: The significant abnormalities found at necropsy were confined to the central nervous system. The meninges showed no gross changes. The brain was of average size and normal in general contours. The convolutions were somewhat flattened and the fissures were narrowed. On coronal sections the white matter appeared to be moderately swollen. About the lateral ventricles, especially in the area of the posterior horns, the large veins were dilated and numerous petechial hemorrhages were present. No distinct softening was demonstrated. The spinal cord and medulla were examined together. The general state of these tissues varied between enlargement, apparently from swelling, and collapse from softening. The markings of the medulla were completely obliterated, and the lower portion of this area was markedly softened and almost semisolid in consistence. Cut surface of the medulla revealed severe central hemorrhagic softening over an area of 4 millimeters in diameter and extending throughout the entire length of this portion of the brain. The cervical segment of the spinal cord was swollen and its landmarks obliterated. The thoracic cord was softened to a point of almost complete disappearance and at this level the tissue consisted of little more than the collapsed, empty meninges containing a small amount of necrotic substance. The lumbar segment showed some remaining integrity of gross outline, but it, too, revealed marked softening on cross section.

Microscopic examinations of sections from the various cerebral and basal ganglion levels showed mild, nonspecific changes. Sections from the wall of the lateral ventricles disclosed dilated vessels about which the tissue was softened and the rim of this softened tissue was being replaced by a mixture of inflammatory elements. Sections from the medulla and spinal cord revealed a picture varying from perivascular inflammation to complete necrosis. In the latter case the tissue was reduced to a structureless mass of debris. In case of the inflammatory lesions not associated with complete widespread disintegration, the lesion consisted of destruction of normal tissue immediately surrounding a blood vessel, usually a vein, disappearance of the myelin and infiltration by a mixture of mononuclear elements.

The pathological diagnosis was: Subacute encephalomyelitis of a disseminated and necrotizing type, compatible with a severe form of postvaccinal reaction.

SUMMARY

1. A fatal case of encephalomyelitis resulting from Pasteur treatment is reported.
2. The literature dealing with the problem of antirabies therapy, its indications, contraindications and complications is briefly reviewed.

ADDENDUM

Since this article was submitted for publication Koprowski and his co-workers[13] published a paper in which they present their experience with antirabies serum. They found that one injection of antiserum, prepared in rabbits and sheep, exerted a definite protective effect in hamsters and guinea pigs. They further concluded that additional use of rabies vaccine neither added to nor detracted from the protective effect of the serum. A small number of humans have been treated with antirabies serum with uniformly good results, but the series is too small to allow one to draw any final conclusions. We shall observe with interest future developments in the field of serum therapy of rabies.

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THROMBOSIS AND DICUMAROL THERAPY*

CHRISTIAN P. SEGARD, M.D.†

NEW YORK, N.Y.

HEMORRHAGIC diseases have, in the past, captivated the attention of the clinician. Thrombotic disorders were viewed with much less interest. In point of morbidity and mortality, however, the latter are of vastly greater importance. To be sure, there were means available for controlling bleeding, while thromboses were without effective therapy. Now, I am pleased to state, the past decade has witnessed tremendous strides in the control and treatment of thrombo-embolic diseases. This is the subject of our discussion.

THROMBOSIS

There is an active chemical process going on during the clot formation. A change from a soluble protein, fibrinogen, to an insoluble one, fibrin, has taken place. Calcium, prothrombin and thrombokinase, the tissue factor, all enter into this clotting mechanism. In high concentration some of these substances may still be only slightly detectable, due perhaps to the relative crudity of our procedures for estimating them. We can only conjecture as to what happens. Reduction in the concentration of any factor may extend the clotting time and thus inhibit thrombosis.

The liver is the source of prothrombin, a clotting factor, the mechanism of production of which requires vitamin K. In the functions of the liver, such as bile production, the rate of formation varies. And this is undoubtedly true of prothrombin. In a state of shock, the liver may function at a very low level. The pendulum of production may swing after shock in the opposite direction beyond the normal amount required and this in turn promote thrombus formation.

Thrombokinase is produced by every tissue in the body. When tissue is damaged by trauma, surgery, parturition or other means, thromboplastin is immediately produced by the disturbed cells and this may lead to a clot in the area or elsewhere. This is nature's method of conserving blood, but going too far.

Within the vascular tree, however, two types of thrombosis are noted. The first is spontaneous, without apparent cause; the other is in response to local or systemic conditions. Increase in activity of one or more of the factors in the clotting mechanism may be responsible as the exciting cause.

The second group, however, offers some clue. In surgery and in parturition we have at least a starting point. The reaction to tissue trauma and shock of varying magnitude may result in thrombotic tendencies by overcompensation of the respective elements which enter into the clotting mechanism. In the presence of local changes that promote the deposition of a thrombus, intravascular clotting may result. In this way thrombosis may begin. Here again we have the pendulum swing following shock.

FACTORS FAVORING THROMBOSIS[1]

1. **Thrombosis follows traumatic injury.** The injury may be from a blow or fall, may follow surgical trauma or childbirth, or may follow splint pressure. The thrombosis does not always involve the veins which were directly associated with the trauma. There are many opinions as to why the clot appears most frequently in the leg veins. Because it does, Homan's sign is an important aid in determining its location. In surgery this phenomenon may appear between the fourth and fourteenth day; seldom before or after, except in cancer. In the case of splints, all too frequently the patient is in distress but endures it, believing it to be associated with the treatment.

2. **Vascular wall injury.** Vascular wall change, such as in the degenerative diseases and in the damaged intima and media of varicose veins, may determine the formation or localization of thrombosis.

3. **Increased coagulability of the blood.** We cannot measure increase in coagulability with the same accuracy we measure decrease. The reason is that the possible magnitude of change in the case of hypercoagulability is extremely small, whereas in hypocoagulability it may be limitless. Nevertheless, one technique which by simple and reliable means may detect hypercoagulability is the Link-Shapiro modification of the Quick method of prothrombin estimation, employing diluted (12.5 percent) plasma as well as whole plasma.

From the fourth to the fourteenth day postoperative and postpartum thrombosis most frequently occurs. The platelets and their contents, thromboplastin, are increased; the liver shock has receded and overstimulation may take its place.

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‡ Medical Director, Wisconsin Alumni Research Foundation.

The platelets may increase in adhesiveness. Excess prothrombin may be produced. Add to this local stasis of blood and injury to venous vascular walls and it becomes apparent. But thrombosis occurs in appendectomy where generally little or no venous disturbance has taken place and again in gut resections where it is considerable. It occurs in gallbladder removal and does not occur in thyroid removal. It occurs from a thigh splint through pressure and probably seldom occurs in a forearm splint. It occurs as an effort thrombosis or through accident.

4. **Infections.**[2] In infections caused by organisms which liberate a coagulase, thrombosis may occur after the infection has become established. In bacterial endocarditis it may be either a coagulase negative or positive toxin. The toxin elaborated by S. Viridans evidently causes thrombotic tendency by a plateletolytic action. S. hemolyticus is both hemolytic and plateletolytic.

5. **Splints.** Where thrombosis follows the use of splints, it occurs after two or three days, but not necessarily at the point of splint pressure. It would seem that thrombosis in many cases is due to local tissue damage, which in turn elaborates a coagulating substance. Thrombosis occurs more frequently in the older age groups.

6. **Frost Bite and Diabetes.** A thrombus may appear and disappear without sign or symptom. While to all appearances it would seem to be a systemic condition, it does localize in certain areas. Jorpes, the Swedish authority, believes that a thrombus usually originates in the plantar area.[3] It then proceeds along the venous pathway and becomes fixed at a point where the intima of the vessel wall has been previously damaged. In about eight to ten hours the thrombus becomes organized. This clot tends to propagate in the direction of blood flow by accretions from the blood stream. Since the area of the damaged wall is covered by the organized part of the thrombus the accretions are attached as the "tail" and may easily become free in the blood stream. This detachment may be caused by muscular activity, trauma, or by the blood stream itself.

The embolus, free in the blood stream, eventually reaches the pulmonary tree, giving rise to pain and infarction of the lung. Its presence and location are determined by pain and localizing physical signs. The plasma prothrombin time will alter if there is shock. Hyperprothrombinemia as revealed by diluted plasma may appear. Frequently these pulmonary cases are mistaken for acute myocardial posterior wall infarction. Changing ECG "right strain" patterns are highly suspicious of pulmonary embolism. Other indications must establish the diagnosis of either acute cor pulmonale or pulmonary infarction. Krauer found fatal pulmonary embolism in 2.5 percent of 33,000 autopsies. Barnes stated that 34,000 die yearly in the United States from pulmonary embolism. Note how these figures coincide.

HEPARIN

The first anticoagulant drug used clinically was heparin. Discovered in 1917, named for its isolation from the liver, given intravenously, its effect is on the coagulation or clotting time of whole blood, since its action is directly on peripheral blood.[3] Given in 100 mg. doses intravenously, its effect may last as long as four to eight hours. Given in delayed action menstruum, several times the above dosage may be used and the action extended over a much longer period of time. Because its effect is immediate and lasts for several hours, heparin is a vitally necessary drug in emergency treatment of thrombotic phenomena.

DICUMAROL*

The discovery of dicumarol resulted from the investigation by Link[4] at the University of Wisconsin of the cause of hemorrhagic spoiled sweet clover disease in cattle. Having isolated the offending substance and synthesized it, the application of the drug to human conditions was an exciting step. Unlike heparin, dicumarol acts in some manner to decrease the liver production of prothrombin. In acute cases of both thrombophlebitis and coronary occlusion, where dicumarol is given, a clinically significant drop in temperature is often noted, as well as relief from pain in about eight to twelve hours. Two methods have been suggested for its use:

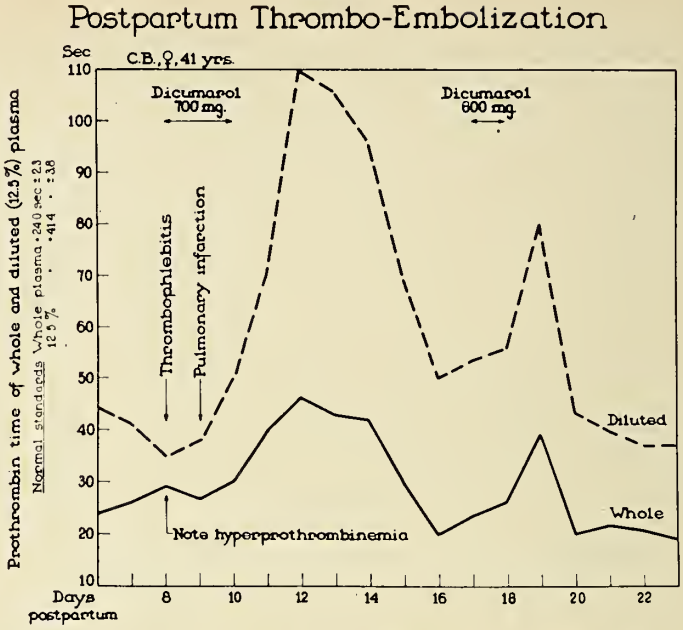
(1) **Maintenance Dose Method:** This method[5] is the most widely used and the one that is easiest understood. A prothrombin determination is made daily. A single dose of 300 mgm. is given the first day (roughly 5 mgm. per kilo). The second day 200 mgm. are given. On the third day 100 mgm.

The prothrombin time now represents the peak of the effect of the first dose. We must now determine the amount necessary to maintain the prothrombin time at the safety level. This is considered to be twice the normal whole plasma prothrombin time and three times the normal diluted plasma time. If the whole plasma prothrombin time on the fourth day of therapy is about twice the normal or approaching that point, no therapy is given. By taking the prothrombin time each day or nearly so, the physician will decide whether to give 50 mgm. or 100 mgm. or no therapy for that day. The maintenance or safety level is sustained in this manner. Less than 5 mgm. per kilo in the initial dose is a mistake, since all the drug that is absorbed is taken up by the tissue and released too slowly to be of therapeutic value. The initial dose must, therefore, be large enough to allow for maximum tissue absorption and surplus for early effect. Later the tissue slowly releases the drug into the plasma. That is why the second and third doses can be much less than the initial dose.

* Dicumarol is the registered collective trade mark of the Wisconsin Alumni Research Foundation, which controls the use thereof.

(2) **Intermittent or Discontinuous Dosage Method:** The method briefly outlined here is the intermittent method recommended by Shapiro.[1] It requires less frequent dosage and less frequent prothrombin estimations (Fig. 1). After the full effect of each dose begins to subside and recovery of the prothrombin time toward normal occurs, another dose is given, the magnitude of which is determined by the weight of the patient and the clinical need. The clinician must bear in mind that once the immediate therapeutic need is overcome then the therapy must be directed toward prophylactic medication to prevent reactivation or recurrence of thrombosis or emboli. The first dose, having a greater absorption, is effective at the time of greatest need. The priming dose is divided in half, given six to eight hours apart. This method also avoids the confusion that arises as to the amount given previously. A day-to-day prothrombin determination is made. The prothrombin time reaches its peak in two or three days and a day or two later a beginning recovery takes place. Early partial recovery indicates the rate of absorption and gives some indication of liver condition. If this partial recovery is slow, liver damage is recognized and increases our vigilance by a lower dose and a more frequent check. Since liver degeneration is more common in the aging, their greater sensitivity to the drug is understood.

Figure 1



The action of dicumarol is to cripple the liver in its production of prothrombin. It must, therefore, be absorbed and metabolized. If diarrhea is present the rate of absorption may be insufficient to cause a change in the prothrombin time and thus a failure to secure the end result desired. The crippling of the liver, however, must not be carried too far. Should the prothrombin time continue to rise four to five days after a dose, this may be considered abnormal. Actually the next dose need not be given until the prothrombin time is halfway back to normal. If it was extended to 38″ in the case of the whole plasma and to 110″ in diluted plasma (Fig. 1), it is allowed to return to about 25″ and 80″ respectively. Note that we use only seconds in recording prothrombin time. This is the way it is read by the technician. Should the prothrombin time become strikingly prolonged beyond the therapeutic level suggested, then vitamin K should be given parenterally to bring the prothrombin time to a safe level. (Do not restore the prothrombin time back to normal, since its therapeutic effect would then be lost.) The drug should, of course, be withdrawn.

TREATMENT

If the condition of the patient demands that the blood be rendered hypocoagulable immediately, then parenteral administration of heparin should be given. The simplest and most reliable method is to give 50 to 100 mgm. intravenously every six hours for three or four days as a single injection each time. Dicumarol is started orally at the same time as the initial injection of heparin. This is given in a single dose of between eight and ten mgm. per kilo, depending upon the clinical need. After forty-eight hours the prothrombin time is estimated, and generally this will be found at the therapeutic level of about double the whole plasma prothrombin time of the normal standard. The diluted (12.5 percent) plasma should be at the level of about three times the normal. There are instances in which, as part of the thrombotic state, the whole plasma will be less apt to become prolonged although the diluted (12.5 percent) plasma will be at the required therapeutic level of hypoprothrombinemia.[1] The reason for this is the accumulated coagulative substances (hyperprothrombinemia), but such patients generally show progressive lessening of this activity as the dicumarol effect is continued.

Since a large initial dose is given, another dose will not be required for several days and then only when the prothrombin time approaches normal. A dose of about 5 mgm. per kilo is then given. The cycle is thus repeated and this intermittent dosage scheme is continued as long as the medication is needed. If at any time the hypoprothrombinemia becomes excessive, a dose of 72 to 154 mgm. vitamin K should be administered parenterally to bring it into a safe range (that is, below the hemorrhagic level).[6]

When bleeding occurs it generally appears first at the site of damaged capillaries. Often purpura appears on the skin, or hematuria may be detected in the urine specimens or on the handkerchief.

LIGATION

Up to a few years ago ligation was in many instances the only treatment in venous thrombosis. While it is still used it is no longer the immediate method of choice. Amputation and ligation are today the last resort. Seen early or late, watchful waiting with an immediate therapy of heparin and dicumarol has proven of value. A recent article (Sequence of Vein Ligation for Thrombosis; Arch. of Surgery 59:633, Sept. 1949) states that while ligation is highly effective in preventing pulmonary embolism, only one-third of the limbs return to normal and the remainder have changes that are seldom severe enough to interfere with normal life. It would seem that a ligation above the popliteal almost always shows edema for a long period and some muscular weakness. Even in the above article the authors state "the phlebograms show that ligation precipitates clotting in the segment lying directly distal to the ligature." Such recanalization as does appear takes place whether anticoagulants or ligation treatment is used.

The surgical vein ligation was an attempt to correct and eliminate the clot. Surgery lays no claim to disposing of the systemic factors involved. Thrombosis is basically a systemic condition and the factors involved are still present regardless of the ligation. Nor does bilateral ligation aid in protection against the killing effect of pulmonary embolism. High ligation may prevent this but the ensuing edema and muscular weakness are complicating factors that cannot be denied. Further, it must be recognized that surgery is one of the proven situations in which thrombosis occurs.

ESTIMATION OF PROTHROMBIN TIME

A number of methods have been proposed for prothrombin estimation. Most were used originally for vitamin K deficiency tests. Coagulation time technique is not sufficiently accurate when dicumarol is used. Coagulation time is satisfactory for determining the level of heparin activity since heparin acts on the gross coagulation of the blood, but in the dosage method described above for heparin-dicumarol therapy coagulation time determination is not needed. Since dicumarol acts on the liver it is far more accurate to measure the activity of a factor present in the first stage of clot formation. Therefore, an estimation of prothrombin activity is essential with dicumarol. The Link-Shapiro modification of the one-stage method[7] of prothrombin estimation is the standard procedure recommended by the American Heart Association and is now being used in most of the well regulated clinics. It demands a standardized thromboplastin whose activity does not vary from day to day. We have found the Maltine thromboplastin most reliable and recommend it be employed. The results should be reported in time, i.e., seconds. The use of percentage figures is misleading and inaccurate. One is estimating only the activity of prothrombin under the prevailing conditions. This should be recorded as such, that is, in seconds.

The factors that make for inaccuracies in prothrombin determination are identical with other laboratory technique. One must avoid tissue juice in securing the sample, oxalate at a proper degree, centrifuge for plasma only, keep reagents, pipettes and other glassware, as well as plasma and thromboplastin, all at the same temperature, and use well-rinsed glassware. Do not rely on a thromboplastin that does not record accurately for both normal and pathic plasma.

The time is recorded in seconds, and reported in seconds with the control report of whole and diluted plasma in seconds. To convert to percentage evokes error since prothrombin activity is not a straight line function. And, it is easier to standardize a thromboplastin than an individual.

There are several conditions that influence prothrombin changes. In the case of diarrhea a great deal of the drug is lost and there may be no change. Aspirin addicts or aspirin in large amounts the day before the therapy is started will cause a decided change in the diluted plasma while the whole plasma is not always affected. The xanthines also affect the prothrombin time and should be kept at a minimum during dicumarol therapy. Our present thought is to avoid continuous use of digitalis leaf. (See infra.)

CONTRAINDICATIONS

There are several conditions in which anticoagulants are contraindicated. Where there is hemorrhage or a tendency to hemorrhage they should be withheld until the condition subsides. The second is malnutrition. Where the protein intake is low or its metabolism is abnormal, as in liver disease, the drug should be given with extreme caution. It should be withheld in the third trimester of pregnancy and during lactation.

When the anticoagulants are used in heart failure the use of digitalis leaf might well be discontinued. Possibly they should be discontinued whether anticoagulants are used or not. This is because the leaf of digitalis contains several saponins, the principal one being digitonin. The saponins in toxic dosage cause hemolysis and no doubt platelet lysis in the amount present in digitalis leaf. Aspirin should never be given when dicumarol is used. Bleeding is much more apt to occur if salicylates are taken with dicumarol.

CAPILLARY HEMORRHAGE

The trigger mechanism by which hemorrhage starts after dicumarol hypoprothrombinemia is not clearly known. There is no fixed level of hypoprothrombinemia at which hemorrhage occurs. The integrity of the capillary vascular wall is the ultimate determining factor. The factors that main-

tain this integrity or restore it under certain conditions are not known. We may, however, postulate an x factor as Shapiro has suggested. This factor is depleted in dicumarol therapy. A partial restoration of the prothrombin time allows the blood or tissue level of this factor to rise.

PULMONARY EMBOLISM

Somewhat similar to the recognition by Hench that in certain conditions there was a recession of the symptoms of arthritis, so Shapiro has presented statistics (in press) indicating that pulmonary embolism is seldom, if ever, seen in thrombosis with cirrhosis of the liver. While it is high in respiratory, neurological and cardiovascular disease, it is very rare in hepatic failure. It may well be that an enzyme fibrinolysin prevents this complication.

Since the objective of anticoagulant therapy is to secure a non-coagulable blood wherein thrombosis will not occur, it would seem a wise procedure to indicate the degree of anticoagulant effect existing at all times during the treatment. The clinician endeavors to secure and maintain a pathic condition of the blood compatible with safety on one hand and adequate therapeutic effect on the other. The technique of prothrombin estimation in dicumarol therapy is different from that used in K deficiency and heparin therapy. In conditions where a blood coagulation time is desired the clinician might well so indicate.

Since the discovery of dicumarol and its application to thrombotic phenomena, several compounds have been investigated for their anticoagulant effect. Tromexan, a Swiss preparation, and pelentan, a Czechoslovakian one, are the same chemically; namely, the ethyl ester of the carboxy biscoumarin. This product is more soluble than dicumarol, therefore absorbed more rapidly but also excreted more rapidly. This is probably not an advantage. Another compound being tried is known as "63." Clinical trials have only recently been started on it and are quite promising. Chemically "63" is 2 methyl-2 methoxy-4 phenyl coumarin.

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ARMY DOCTORS TEST NEW BURN DRESSING IN KOREA

Two new oversized dressings for burns or wounds will soon join other medical advances which help to provide the best medical treatment obtainable to G.I.'s fighting in Korea, according to Major General R. W. Bliss, Army Surgeon General.

One of the projects of the Army Medical Service's Research and Development Board, the new dressings consist of an inside or wound layer of highly absorbent fine mesh gauze, which may be treated to reduce irritation to wounds; and an outside, nonabsorbent layer that prevents bacteria from entering the wound or burn. These qualities will permit the dressings to be worn for as long as 14 days, whereas present type burn dressings must be changed every day or two, depending upon the degree of the burn.

Smallest of the dressings, 19 by 34 inches, are about five times larger than the largest size now in use. The larger one, for more extensive burns or wounds, is 34 by 45 inches. These dressings were developed for use during the first aid phase of treatment to give the casualty every benefit of Army medical research possible, and to improve his chances of reaching a hospital for definitive treatment.

These dressings will offer much greater protection to a large burned area, such as a tanker might sustain when his tank is hit, or a soldier might receive from the burst of a high explosive bomb. In the case of severely burned extremities, a dressing can be wrapped around the affected part.

Wounds resulting from blast, where small particles of loose debris have entered the skin over a considerable area, may also be treated with the dressings. In the event of an atomic bomb burst, both dressings would be invaluable.

The smaller dressing also may be used as an arm splint when tightly applied. The dressings are packed in a plastic bag that is resistant to water, moisture, and heat.

TWINS: ONE MACERATED; THE OTHER NEAR TERM AND NORMAL

Case Report

MATTHEW CORNACCHIONE, M.D., M. H. GOTLIB, M.D.*
WM. HUSE, M.D.,* J. I. TAUBE, M.D.†

INDIANAPOLIS

THIS CASE is presented for the purpose of reporting a twin pregnancy with an unusual complication. A living, normal, near term infant was delivered, followed by delivery of a macerated fetus. Only eight somewhat similar cases have been recorded in the available medical literature. [1, 2, 3, 4, 5, 6, 7, 8.]

This patient was thirty-five years of age, white, and had had one previous normal pregnancy thirteen years ago. At that time she was in active labor for twenty-five hours and a normal female infant of seven pounds, fourteen ounces, was delivered by low forceps, preceded by a left mesiolateral episiotomy. Postnatal course was uneventful.

She was seen on October 5, 1948. Her last menstrual period had started on July 16, 1948, thus making the expected date of confinement about April 22, 1949. Her complaints at this time were severe nausea, vomiting, and mild anxiety and tension. Menstrual history revealed onset of menses at the age of twelve, regular, without pain, and of five to six days' duration every twenty-eight days. Family history was non-informing. The general physical examination revealed nothing unusual except a mild secondary hypochromatic anemia. Her weight was 104¾ pounds and her height 5′ 2½″. External pelvimetry revealed the following: interspinous 24.5 cm.; intertrochanteric 30 cm.; right internal oblique 28 cm.; external conjugate 20 cm. The height of the fundus was that of about a three months' gestation. The blood pressure was normal and the urinalysis was within normal limits. The results of serological tests were negative and she was Rh positive. She was given one cc. of pyridoxine hydrochloride intramuscularly. Phenobarbital, ¼ grain, three times daily, along with two capsules of dicalcium phosphate with iron and vitamin D, three times daily, were prescribed.

Past medical history was negative except for usual childhood diseases, with good recovery and no sequelae; no history of injuries or of surgical procedures. Her occupation was that of housewife.

Patient was seen again on October 15, 1948, and received one cc. of pyridoxine hydrochloride intramuscularly, which was repeated again on November 2, 1948, with 50 cc. of 50 percent glucose intravenously. Oral medication was discontinued because of vomiting, and seconal sodium, grain ¾, per rectum, was prescribed to be used as needed. Vomiting persisted to mid-November but any attempt at oral medication resulted in prompt regurgitation of same.

Subsequent examinations revealed a normal weight gain and all physical findings remained within normal limits until January 25, 1949, when a one-plus albuminuria was found, but cellular elements of urine were absent. Patient complained of marked abdominal distention and discomfort. It was noticed previously that the uterus was increasing rapidly in size and that fetal parts were indistinct because of large fluid content and abdominal tenderness. At this time the height of the uterus extended to the xiphoid process. Large fluid content of uterus was noted and fetus was in a cephalic presentation, but because of multiplicity of fetal parts and large fluid content of uterus, an x-ray was requested.

After considerable insistence the patient had an x-ray taken, on February 14, 1949. Interpretation of x-rays by Drs. Ralph L. Lochry and C. C. Taylor revealed a twin pregnancy. The dependent fetal skeleton was in cephalic presentation with the spine on the right side, and this fetus appeared normal. The second fetal skeleton was on the left side and the skull bones were overriding, and it was believed that this fetus was not viable.

The patient's general physical condition remained within normal limits. The albuminuria persisted and on March 7, 1949, a few coarse and finely granular casts were found. Moderate edema of legs and ankles was noted. The hypochromatic anemia persisted. Patient was extremely uncomfortable due to marked uterine enlargement, and a moderately severe anxiety state was prominent. Nausea and vomiting recurred. Being confronted with a twin pregnancy, with one babe having been dead for at least two months, and with the abovementioned findings on March 7, 1949, together with coincidental urinary findings at about the time of the death of the one babe, with progressive though

* Residents in Obstetrics and Gynecology, St. Vincent's Hospital, Indianapolis.
† Intern in Obstetrics and Gynecology, St. Vincent's Hospital, Indianapolis.

Figure 1

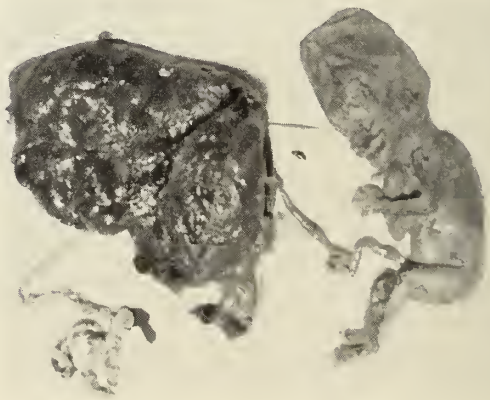
slow toxemia, it was thought best to terminate the pregnancy by induction of labor by rupture of membranes and by manual stripping of membranes and cervical dilatation.

The patient was admitted to the hospital at 8:00 a.m. on March 23, 1949. Physical findings were the same as mentioned. The fetal heart rate was 136, strong and regular. Patient was taken to delivery room at 9:30 a.m., and prepared. Under light ether inhalation anesthesia, examination revealed cervix to be about two fingers dilated and about 60 percent effaced. The presenting part was at minus one station. The membranes were stripped and ruptured and cervix was very gently dilated. At 10:30 a.m. patient complained of cramp-like pains, accompanied with oozing of amniotic fluid. At 11:45 a.m. contractions were irregular, about every five to ten minutes. At 12:25 p.m. contractions were every five minutes and more severe. Nembutal, grains three, was given to the patient. At 12:45 p.m. contractions were every five minutes, lasting about fifty seconds, but she rested well between pains. Demerol, 100 milligrams, and scopolamine, grains 1/150, were given subcutaneously. Rectal examinations at intervals revealed good progress and there was no doubt but that the patient was in active labor. Did intervention precipitate this labor?

At 4:30 p.m. the patient was taken to the delivery room. Duration of labor was more than five hours. Under ether anesthesia the first twin, cephalic, crown in L.O.A. position, was delivered by easy low forceps at 5:06 p.m. The dead male twin was felt to be presenting as a breech. The membranes were ruptured and a small quantity of thick light brown fluid with fine granules escaped. The legs were brought down and the head and upper trunk of the fetus were delivered, enveloped in the membranes, at 5:12 p.m. The fetus was thirteen inches long and weighed 10½ ounces. It was flattened and yellowish brown in color and surprisingly well-preserved. The living male babe weighed five pounds, thirteen and one-half ounces, and appeared to be normal in all respects. The placentas were expressed, apparently intact, at 5:18 p.m. Blood loss was estimated at about 130 cc. No lacerations were present. Patient was given one cc. of ergotrate intravenously at completion of delivery of second twin. The placentas were fused and appeared to be of uniovular origin. The placenta of the living twin appeared normal in all respects as to size, color and consistency. The placenta of the dead twin was thick and rolled-up, forming a cylindrical mass, with the fetal surface covering most of this mass and the area of uterine attachment being markedly reduced.

There was a marked difference in color between the two placentas which very sharply delineated the line of fusion. There was no evidence of early separation of the placental attachment. The placenta in uniovular twins or homologous twins is single, usually with two cords. There is usually a higher mortality and babes are more often deformed. The twins are of the same sex, as were these. The two circulations anastomose in a com-

Figure 2



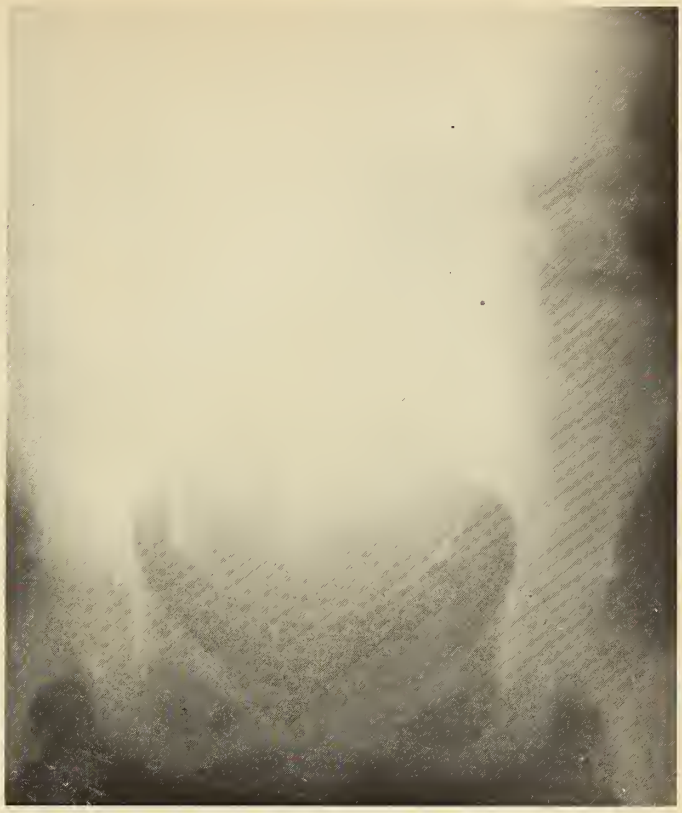
mon placenta. Nausea and vomiting are usually exaggerated. Toxemia and edema are usually more marked. Premature labor occurs oftener because of overdistended uterus, lower uterine segment, and cervix being developed earlier than usual. Birth of one-egg twins are uncommon. The twins were side by side.

The death of the twin fetus occurred at about the sixth month. This is arrived at by x-ray findings and last menstrual period and estimated date of confinement. It is believed that death of the fetus occurred when the area of placental attachment became inadequate for the nutrition of the fetus for causes unknown.

The living twin was last seen January 3, 1950, and weighed twenty-three pounds and five ounces, and measured 76 cm. and was normal in all respects; in fact, above average.

A point of interest in this case is that a dead twin fetus was retained over a period of weeks or months without exerting any toxic or deleterious effect on the other twin or to any marked degree on the mother.

Figure 3



While preparing the preceding case for publication, the following case was admitted to the same institution, and with the kind permission of Dr. B. K. Westfall it is also presented.

Mrs. N. H., a 27-year-old Gravida II, Para I, first saw Dr. B. K. Westfall at about eight months gestation, having moved to Indianapolis from another city at that time. The pregnancy in the early trimester was uneventful save for minimal nausea and vomiting. The first day of the last menstrual period occurred on March 25, 1949, and the estimated date of delivery was January 2, 1950.

Past history revealed no major illnesses or surgery and the patient had delivered a normal, eight-pound infant seven years previously, without complications save length of labor, thirty-six hours. Weight gain during present pregnancy was twenty-eight pounds.

On January 17, 1950, at 11:55 a.m., the patient was admitted ambulatory to the labor room and shortly afterwards the membranes ruptured spontaneously. Physical examination at this time revealed a well-developed, well-nourished white female having mild uterine contractions every eight to ten minutes. Pulse was 88 per minute, full and regular, blood pressure 120/70, temperature 98.4. External measurements were as follows: crests, 25 cm.; spines, 22 cm.; and the bi-ischial, 4 cm. Examination of head, neck, and thorax revealed no abnormalities. Palpation of abdomen revealed the fetus to be in right occiput transverse position. The fetal heart rate was full and regular with a rate of 140 per minute.

Rectal examination at time of admission was reported as 3 cm. dilatation of cervix, 70 percent effacement, station O, with a cephalic presentation. At a later rectal examination, at 3:00 p.m. on the admission date, it was noted that the presenting part felt abnormal and consequently an x-ray of the abdomen was ordered. This was taken within the next hour and revealed a normal single fetal skeleton in cephalic presentation in an apparent right occiput anterior position, with the head located over the sacrum. Inferior to this fetal skeleton was a small fetal skeleton in cephalic presentation with the fetal head collapsed, indicating its nonviability. The maternal pelvis appeared normal. (See Figure 3.)

At 4:30 p.m. on January 17, 1950, the patient was taken to the delivery room, and at 4:43 p.m. a stillborn male infant, measuring 24 cm. in length, was spontaneously delivered. No attempt was made to express the placenta and the patient was returned to the labor room, where she continued to labor with irregular contractions.

On January 18, 1950, at 2:00 p.m., due to continued variation in fetal heart rate from 96 to 136 per minute, the patient was returned to the delivery room. At this time the cervix was 6 to 7 cm.

dilated and membranes were intact. The membranes were ruptured and heavily meconium-stained water escaped. A right occiput posterior position was rotated manually to a right occiput transverse position, forceps applied through the cervix, and with slow interrupted rotation and traction over a fifteen to twenty minute period, a live male infant was delivered at 2:37 p.m. The cervix dilated slowly and only one minor laceration was encountered, which was repaired with chromic OO. The placenta appeared to be uniovular and the portion to the dead twin was entirely infarcted.

The puerperium in the hospital was normal and the patient was dismissed on January 21, 1950.

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NEWER CONCEPTS OF INTESTINAL OBSTRUCTIONS

E. L. C. Broomes, M.D.

EAST CHICAGO

IN SPITE of the monumental works of Miller, Abbot,[1] Wangensteen, Dragstedt and others, and the phenomenal success in reducing mortality, following the application of the principles of water balance and tubal decompression, intestinal obstruction still remains a grave surgical problem. While the diagnosis is seldom ever long in doubt, the particular treatment approach applicable is not always readily determined.

Any system of treatment, to be intelligent and effective, must be based on concepts that are logical and proven, which can only be acquired from an accurate knowledge of the intestinal tract, not only in its normal state, but also when, through disease processes, the anatomy has been distorted and the physiology disturbed.

A brief review of some of the more or less well accepted concepts of the gut might be of advantage at this point.

(1) The gut is a muscular tube extending from the esophagus to the anus, and with the exception of such temporary interruptions as are produced by the sphincters of the pylorus and the ileocecal valve, it is patent throughout its entirety.

(2) The primary functions of the gut are nutrition and excretion.

(3) Rythmical, wave-like, pendulous, contractile movements known as peristalsis sweep caudally through the entire length of the gut at frequent intervals. These segmental waves are responsible for the downward movement of the food.[2] Usually peristalsis is a subconscious activity. The individual is seldom aware of these intestinal activities.

(4) Under normal conditions antiperistalsis, that is, retrograde waves, traveling cephalad, do not occur.

(5) During every 24 hours at least eight liters[2] of fluid from the pancreas, gallbladder, and glands of the succus entericus are poured into the duodenum. This fluid contains, among other substance, enzymes and catalysts for digestion. It is rapidly reabsorbed as it travels down the tract, so that by the time the cecum is reached only a thick viscous mass remains.

(6) The feces consist chiefly of cellulose, bacteria, indole, skatole, and histamine.[2] The cellulose represents the indigestible portion of the food. Since normally the fat, protein and carbohydrate of the diet are practically all absorbed, it would appear that the bulk of the feces is composed of endogenous substances. This belief is strengthened by the fact that a seg-

ment of the bowel isolated from the rest of the tract becomes, after a time, packed with a mass of fecal matter, which, of course, must be endogenous.

When following some catastrophe the patency of the tube becomes interrupted, a train of events rapidly follow, which at first are reflected in symptoms purely local, then later by reactions which are more or less generalized and systemic.

The earliest sequel of an obstruction is a rapid accumulation of fluid above the obstruction point. The patient becomes aware of a feeling of heaviness and fullness.

The peristaltic waves described above, blocked in their transit by the obstruction, grow in intensity, as nature makes violent efforts to rid itself of the barrier. The patient now becomes acutely conscious of sharp crampy pains. If the abdomen is auscultated[3] at this time it will be noted that these pains correspond in time and intensity to the abnormal peristalsis.

Vomiting, which is the next symptom to follow in this order, is due perhaps to the development of abnormal intestinal waves, known as antiperistalsis; these are retrograde in movement, and arise as excitatory waves from the rebound of the peristalsis against the barrier. This backward movement releases temporarily the forward pressure of the accumulating fluid on the distal portion of the obstructed segment, and since the proximal portion is an area of relatively low pressure, the fluid is readily ejected backwards and out, and the patient vomits.

Perhaps the most severe systemic reactions following an obstruction result from a loss of the body fluids and a depletion of the plasma proteins. Formerly it had been thought and taught that this was due directly to the severe vomiting, but this is no longer strongly adhered to. The experience of every gynecologist with patients who vomit almost continually during their gestatory period, with little evidence of gross physiologic disturbance, forced a modification of this view. Vomiting, as it will be shown immediately, plays but a secondary role in the dehydration of intestinal obstruction.

In the physiology of the circulation the vital process is the interchange of water and nutrient solutes across the semipermeable membrane at the capillaries. This interchange which takes place between the blood vessels and the perivascular tissues is due primarily to two factors, the propulsive force of the hydrostatic pressure of the arterial blood and the attractive force of the plasma proteins. On the arterial side oxygen and other nutrient solutes essential to cell anabolism are pushed across the capilliary walls into the perivascular spaces, whence they are collected by the cells. On the venous side, a correspondingly reverse process takes place. In the absence of any significant hydrostatic force, the plasma proteins exert a positive osmotic pressure, and fluid from the interstitial spaces containing carbon dioxide and other end products of cell catabolism are drawn into the circulation. Of course, there are other factors, such as perivascular hydrostatic pressure due to tissue elasticity, and perivascular osmotic pressure due to the presence of proteins in the interstitial spaces; but the role of these is insignificant. When the gut begins to distend, the thin walls of the intestinal venous capillaries are compressed. The circulation becomes impaired. After a while, these fragile walls are injured and become permeable, so that the plasma proteins readily escape out into the perivascular spaces. The consequence of this is indeed profound. The physiologic equilibrium of the body is disturbed. The arteries being more resistant to compression, because of their tougher walls, continue to filter fluids into the perivascular spaces. With the collapse of the venous return system, there is a growing accumulation of fluid in the intercellular spaces. The amount of fluid so lost to the circulation is enormous. While there is a progressive edema of the tissues on one hand, there is on the other a severe dehydration of the circulation which leads to hemoconcentration, which leads to inadequate renal filtration, which leads to oliguria, then increased N.P.N. acidosis and uremia.

If the condition continues unrelieved there is developed, in addition, a severe secondary anemia.[4] The arterial capillaries, the tough walls of which had resisted the earlier effects of the distention, continue to be subjected to a growing pressure from the progressive expanding of the intestinal walls. With the hydrostatic pressure of the blood from within, and the compressive pressure from the distending bowel without, the capillary walls are pinched vice-like between these two forces. The inevitable happens. The ischemic walls rupture, and the red blood cells leak into the lumen of the intestines and into the peritoneal cavity.[4] The amount of blood which can be lost in twenty-four hours is not readily calculable. Autopsy findings of patients dying from intestinal obstruction invariably show massive amounts of dark blood in the lumen of the gut and in the cavity of the peritoneum; enough, at times, to justify the conclusion that exsanguination might have been the terminal factor.

Everyone is aware of the fact that even at the terminal stage a hemoglobin reading or red blood cell count might show values that are normal or even higher than normal, and unless the dehydration and hemoconcentration concomitant with intestinal obstruction are kept in mind, such reports can be dangerously misleading. Blood counts not corrected by the hematocrit are useless.

While constipation is the rule, the passing of formed stools cannot be considered as ruling out obstruction, since, as it has been briefly mentioned above, the formation of feces is largely endogenous. During starvation feces which do not vary signifi-

cantly in composition are formed and excreted. It has also been shown by experiments that segments of the gut, isolated from the rest of the intestines can continue to form fecal-like matter.[2, 5] It is now believed that the presence of such exogenous substances as food particles only stimulate the formation of feces. The absence of peristalsis below the point of obstruction is perhaps the most important factor in causing the constipation.

Until recent years the entire philosophy of the treatment of bowel obstruction was contained in the following adage "Never let the sun go down on an intestinal obstruction." Today, because of a better understanding of the body physiology, and of the various systemic changes incident to bowel obstruction, the modern concept may now be expressed as "Never let the vital fluids go down, even if the sun does."

The general treatment would, therefore, embrace two phases:

(a) Restoring and maintaining the physiological equilibrium.[2, 6, 11]

(b) Resolution of the obstruction.

The order in which either of these two measures is applied can only be determined by the particular circumstance of each case.

If the obstruction has lasted for some time, and there is evidence of dehydration and other systemic changes, surgery should be postponed, and efforts concentrated on restoring the water balance and plasma protein level. The necessity of maintaining the blood volume by adequate transfusions should not be overlooked. Meanwhile, temporary relief might be given by means of Wangensteen suction intubation.

Although the restoration of the chloride and sodium ions is perhaps the most important single preoperative measure, nevertheless the indiscriminate administration of large quantities of normal saline is not without serious danger.[7] An excess amount of sodium ions transposed into tissues already water-logged would but aggravate the edema. Under normal conditions the body can utilize daily a maximum of 8 to 10[1] grams of sodium chloride. This is approximately the amount of salt contained in a liter of normal saline; hence, at the most, no more than 1,500 cc. of N. saline should be given during any period of twenty-four hours. In addition to this about 2,000 cc. of 10 percent glucose in distilled water and 500 cc. of plasma should provide adequate fluid intake for one day.

While the basis for the administering of oxygen in high concentration is perhaps a logical one, the practical value or efficacy is open to question. It is true that in every obstruction gases play a significant part in the ensuing distention. Most of these —oxygen, carbon dioxide, methane and hydrogen sulfide—are readily diffusible, and can easily escape from the bowels, and so offer no particular problem. Nitrogen, on the other hand, because of its poor diffusibility constitutes most of the gas found in the distended segment. It is believed that by giving high concentrations of oxygen the latter might displace the nitrogen of the blood, and so allow the nitrogen in the bowel to diffuse into the blood stream. Since, however, the original cause of the accumulation was not a deficiency in the oxygen tension, but rather an interruption in the physiologic interchange of gases between the bowel and the blood stream, due to a local collapse of the venous system, it is difficult to justify oxygen therapy on any other basis but that of wishful thinking.

Although it is not the purpose of this paper to discuss surgical procedures, mention will be made briefly of two concepts that might be considered as embodying the present-day philosophy of the surgery of the obstructed gut; the first is well established and well accepted, and that is "Never do an anastomosis on an edematous gut."[9, 10] The second, while on an equally firm base, is not as generally admitted, "Never do a high ileostomy."[11] The reasons given are convincing. The large amount of endogenous body fluid that is poured into the duodenum daily is normally reabsorbed in the jejunum and the ileum. This fluid contains not only electrolytes, digestive enzymes and catalysts, but also certain substances indispensable to the process of food absorption, the presence of which have been suspected although not as yet definitely identified.

A high fistula would siphon this vital fluid to the outside and because of the endogenous source of most of its constituents, successful replacement by parenteral infusions cannot be assured. In addition, because of its proteolytic and lipolytic properties, there would be the ever-present danger that any leakage would cause a digestion of the suture lines and so predispose to evisceration; seepage on the surface would cause excoriation around the ostium.

The circumstances that can justify a high ileostomy are rare indeed. Because of the dramatic onset and alarming symptoms of a very high obstruction, medical aid is usually sought early enough so that a primary resection, if indicated, can be done immediately. Moreover, gross distention is seldom a significant feature of very high obstruction.[12] The frequency and completeness of the vomiting is certainly not conducive to fluid or gas accumulation. If for any reason temporization before surgery is necessary, the use of an ordinary stomach tube or a Miller-Abbot modification would ensure adequate decompression.

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Case Report

PREVENTION OF DEFORMITIES WITH TOLSEROL

Francis A. Streck, M.D.

LAWRENCEBURG

TOLSEROL (Mephenesin, Squibb) has the property of reducing muscle spasm.[1] Recently I have had occasion to use it in two cases of selective paralysis with very encouraging results.

CASE ONE

On May 26, 1950, a fifty-five-year-old, white male, who had previously had amputation of both lower extremities because of vascular occlusion with gangrene, suddenly developed paralysis of the extensor muscles of the right forearm. He had had no prodromal symptoms and it was impossible to determine the exact cause of the disorder. This patient had extreme spasm of the flexors of the forearm and hand with a resulting "claw hand" deformity. The spasm was so intense that it was almost impossible to extend the fingers by external force. The patient was given one teaspoonful of Elixir Tolserol after meals and at bedtime. Within twenty-four hours the muscle spasm relaxed. The hand was normal in appearance although there was still a tendency to flexion in the thumb. The patient was instructed to extend the affected fingers and wrist passively. Motor paralysis of the extensors persisted for about six weeks, after which there was a gradual return of function. Some residual weakness persists.

I feel that Tolserol was valuable in preventing deformity in this hand until nature restored function in the affected muscle group. Because of the definite good results in this case, I was prompted to use Tolserol in a case of poliomyelitis which presented a similar picture.

1. Schlesinger, E. B.: Clinical Applications of Myanesin, Tr. N. Y. Acad. Sc. Ser. II, Vol. II, November, 1948, No. 1, p. 5.

CASE TWO

J. K., age seven years, was first seen on July 25, 1950, because he fell when he attempted to walk. His mother stated that he had complained of a headache and had not felt well for two days. On the morning of examination he had been unable to walk. Temperature was 100.6, pulse 100. His neck was moderately stiff and attempts to flex the head caused pain. The extensor muscles of the left thigh were paralyzed. His knee was held in partial flexion and attempts to straighten the leg caused acute pain. Tolserol, one-half teaspoonful four times daily, was given. Within twenty-four hours the patient was free from pain and the flexion deformity was completely overcome. The patient was kept at rest until function began to return. He was given gradually increasing exercises until now he is walking with no perceptible limp.

SUMMARY

Two cases of selective paralysis are presented in which Tolserol was useful in preventing deformities.

CONCLUSIONS

1. Tolserol is successful in preventing deformities in selective paralyses such as occur in poliomyelitis.

2. These findings demonstrate the need for controlled studies of action of Tolserol in these cases.

3. If findings are substantiated, many crippling deformities can be prevented, and the cost of care in certain polio cases can be materially reduced.

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GOOD MEDICAL SERVICE

AN OVERALL report on the health and medical care of the armed forces in Korea has recently been released by General R. W. Bliss, Surgeon General of the Army. Despite the fact that the campaign was fought without prior planning, and in spite of the world's worst environmental sanitary conditions, the general health record and the survival rate of the wounded has been better than even the excellent records of World War II.

Of 18,000 men admitted for all causes to one evacuation hospital in Korea during a three-month period, only 40 lives were lost.

The mobile surgical hospitals which treated only the most severely wounded, and did so under front line conditions, have accomplished the remarkable record of only one death for each 100 admissions.

It has become axiomatic that a wounded member of the American armed forces who reaches a hospital alive has a splendid chance of recovery. In World War II three of every four men hospitalized for wounds recovered completely enough to return to duty. The medical departments of the Armed Forces have improved on this record in the Korean fighting. They have improved on the axiom, and have performed a service of which the medical profession can be proud.

The prevention of disease in Korea has been no less spectacular than the treatment of wounds and injuries. While the combat has taken place in a highly malarious zone during the peak of the malaria season, the incidence of clinical malaria in the fighting forces has been exceedingly small. Gastrointestinal disorders have been limited to occasional cases, in spite of a most insanitary environment. Tetanus, cholera, typhoid fever, hepatitis and smallpox have not occurred in a single instance.

General Bliss gives credit for the record to the adherence by the armed forces to four basic principles.

The first of these is the planning and medical logistical operations which were accomplished in a first-class fashion.

The second was the preventive medicine program which succeeded in holding preventable diseases to a minimum.

The third element was the high level of professional skill exhibited by all medical personnel, made possible by the residency training program which the armed forces have conducted since the end of World War II.

The fourth credit is given to the laboratory and research program, carried out in the Far East Command, and which was concerned principally with problems analogous to those encountered in Korea.

General Bliss made special mention of approximately 100 young medical reserve officers who joined the fighting precipitously, at the conclusion of their postgraduate professional training. He has the highest words of praise for the way in which they have integrated themselves with the regular service.

OVERHOSPITALIZATION

THERE is a natural tendency for people to want to "get their money back" when they have paid for insurance to cover some hazard in their lives. Some forms of insurance, notably life insurance, are free from this temptation. However, hospitalization insurance is one form in which the problem of overutilization and misuse is a real problem.

The difficulty lies in the fact that the circumstances under which the insurance carrier is liable cannot be defined exactly. Hospital insurance premiums are based on the expectation that major illnesses will be covered, minor illness and diagnostic work will not. The severity of sickness and the actual need for hospital care are matters of judgment, and often the patient's insistence is the factor which decides the issue.

The premium necessary to support insurance which would be able to hospitalize every patient, no matter how trivial the illness, would be prohibitive. It is therefore the custom to sell hospital insurance at a cost which is calculated to cover the expenses of only the seriously ill, those people who would be hospitalized even though they were to pay the bill directly.

If patients are hospitalized with minor illnesses or for diagnostic procedures, hospital insurance companies will find it necessary to charge higher premiums in order to remain solvent. If overhospitalization becomes a widespread practice, the costs will rise until the companies are priced out of business.

Dr. Paul R. Hawley has recently called attention to the dangers of the situation, particularly as it affects the operations of the various Blue Cross agencies. Blue Cross in general, the country over, has done a remarkable job of keeping pace with the rising costs of hospital operation.

Premiums have increased only slightly as compared with the rise in hospital costs. However, no insurance system can withstand the inroads of mounting legitimate costs and the millstone of overutilization at the same time. Now is the time to curb abuses, if the voluntary system of insurance is to survive.

Two classes of people are vitally interested in voluntary hospital insurance; each class must cooperate with the other in order to make the system a continuing success.

The policyholders and potential patients have a large stake in the enterprise. It is essential that they be informed so that they may do all in their power to promote proper use of the insurance, and thus preserve their protection against the cost of serious illness.

The doctors are interested, too. Voluntary insurance is a tremendous aid to the practice of medicine, and it is also the principal bulwark against the possibility of compulsory government insurance.

The insured persons and the doctors are not only the ones with the greatest interest in the problem, but they are also the only ones who can solve it. They must do this in cooperation with each other. Public education will be necessary. That portion of the public which is forehanded and provident enough to provide themselves with voluntary prepaid hospital care will readily understand the necessity of operating it in a manner which will maintain solvency, and keep the cost low enough so that all may afford it.

UNCANNILY PROPHETIC

A FRIEND of ours once went to considerable pains to prove that there is "nothing new under the sun." The other day we ran across this uncannily prophetic quotation that seems to bear him out.

It was written in the year 1834 by the French author, Alexis de Tocqueville. We quote it below without further comment:

"Today there are two great peoples who, starting from different points, seem to approach the same destiny; they are the Russians and the Americans. Both of them have grown in obscurity, and, while men were looking the other way, they have suddenly reached the first rank of nations. . . .

"All other peoples seem to have nearly reached the limits of their potentialities. . . . But these two peoples are growing. These alone follow a course whose limit the eye cannot yet detect.

"The American battles the obstacles of nature; the Russian, those of man. The former combats the wilderness and savagery; the latter, civilization with all of its weapons. American conquests are won with the laborer's ploughshare; Russian triumphs with the soldier's sword. To attain its ends, the American relies upon personal interest and allows free scope to the unguided energy and common sense of individuals. The Russian somehow concentrates the power of society in one man. The method of the former is freedom; the latter, servitude.

"Their starting point is different, their ways are diverse, and yet each of them seems called upon by the secret design of Providence to control, some day, the destinies of half the world."

—Portland (Ind.) *The Graphic and Pennville Booster*

President's Page

THE PROBLEM OF CHRONIC ILLNESS

THE FACT that the average baby born today in this country may expect to live to the age of sixty-seven years creates some problems for society, and especially for the medical profession, which formerly did not exist. This remarkable increase in the life span has been due principally to advances in the control of communicable diseases. Within the professional lifetime of many of us we have seen the waning of smallpox, diphtheria, typhoid fever and many other such diseases, until now there are many students leaving the medical schools who have never seen examples of some of these diseases. The present-day doctor, however, is a very busy person because of the increase, firstly, of psychosomatic diseases brought on by the tension of modern-day activities; secondly, because people are becoming much more health-conscious; and thirdly, because we are called on to give more attention to those who are chronically ill. Until recent years the physicians' time was taken up largely by those who were acutely or critically ill, but more recently the emphasis is shifting towards those who are chronically ill. Chronic illness, of course, affects those in the older age brackets because many of the chronic illnesses are a result of degenerative processes. We must remember, however, that so-called chronic illness affects many people in the younger age groups, realizing that a list of the most important chronic diseases should include tuberculosis, diabetes, kidney disease, cancer, asthma, heart disease, arthritis, arteriosclerosis, high blood pressure and nervous and mental diseases.

The problem of the chronically ill is growing in magnitude so much that our Governor has set up a commission to study this matter. Also, the American Medical Association, in cooperation with several other agencies, is setting up a commission to study the problem of the chronically ill. It is obviously appropriate, therefore, that our State Medical Association take recognition of this trend of our changing times and take active part in studying these problems. The leadership in problems of health belongs with doctors of medicine. The future of our position in such matters depends surely upon our attitude and actions regarding them now. In view of these facts we are establishing a committee from our membership whose function it will be to study the problem of chronic illness and to help point the way for better service to these patients.

* * * * *

Merry Christmas To You

Christmas-time will soon be here. It is probably the finest time of the whole year, for the reason that most of us open our hearts a little wider and more nearly emulate Him who taught us the Golden Rule. This is the rule that could lead the world to happiness if its worth and beauty were appreciated by everyone.

May your Christmas-time be Merry and be filled with Happiness and Joy, and may the New Year be one of great satisfaction and interest to you. And may one of the things that comes to you this Christmas-time be a greater appreciation of America.

Alfred Edison

SALT SOLUTION BY MOUTH IN TREATMENT OF BURN SHOCK

A GROUP of leading American surgeons has advised the Public Health Service, Federal Security Agency, that salt water taken by mouth, in a vast majority of cases, is as effective as blood plasma in the emergency treatment of shock from serious burns and other injuries.

The recommending surgeons are members of the Surgery Study Section, an advisory body to the National Institutes of Health and to the Surgeon General of the Public Health Service.

In general terms, the treatment calls for approximately one level teaspoonful of table salt and one-half teaspoonful of baking soda for each quart of water. A number of quarts are required each day. The only limitations on the amount consumed is the ability of the patient to consume the saline solution. Since great thirst accompanies serious burn injury, it has been found that patients will voluntarily consume a sufficient amount of the solution, which is quite palatable. No other drinking fluid is permitted in the first few days following injury.

In releasing the recommendation, which came to the Public Health Service as the major Federal Agency charged with responsibility for civilian health, Surgeon General Leonard A. Scheele said:

"The findings are of particular importance in a period of war emergency, since it is estimated that in the event of atomic bombing about 60 percent of the surviving bombed population might suffer from burns. This figure, moreover, does not account for injuries other than burns in which shock also might be present.

"Salt water offers an easy, practical method for the treatment of shock which follows serious burns and other injuries. It is particularly important in any period of large scale disaster. Unless the patient is disoriented, is in acute collapse or is among the very small percentage who become nauseated by drinking large quantities of the salt solution, the sodium chloride formula will be effective when administered by mouth."

Doctor Scheele emphasized the fact that treatment by saline solution will in no sense decrease the need for whole blood. Rather, he pointed out, sodium chloride would provide an effective immediate form of treatment which could be administered by anyone.

"The recommendation of the Surgery Study Section, while of enormous benefit in the event of large scale disaster, must not be construed as lessening in any way the importance of blood bank programs," he said. "Whole blood and plasma are still essential.

"We believe that the salt water method of treatment should also be included, however, in Red Cross training programs so that the necessary information may be fully available to all first aid personnel, including firemen, policemen, air raid wardens and housewives."

Membership of the study section is as follows:

Dr. Frederick A. Coller, professor of surgery, University of Michigan, chairman; Dr. Claude S. Beck, professor of neurosurgery, Western Reserve University; Dr. Loren R. Chandler, Dean, Stanford University Medical School; Dr. Lester A. Dragstedt, professor of surgery, University of Chicago; Dr. Daniel C. Elkin, professor of surgery, Emory University; Dr. C. A. Moyer, Dean of the Southwestern Medical School of the University of Texas; Dr. Harris B. Shumacker, Jr., professor of surgery, Indiana University Medical Center; Dr. Owen H. Wangensteen, professor of surgery, University of Minnesota; Dr. Allen O. Whipple, clinical director, Memorial Hospital, New York City; Dr. H. L. Skinner, chief of surgery, Staten Island Marine Hospital; Dr. Henry Beecher, professor of anesthesiology, Harvard University Medical School; Dr. J. Gordon Lee, chief of surgery, Mount Alto Hospital, Washington, D.C.; Dr. Howard R. Lawrence, chief of surgery, Francis E. Warren Air Force Base Hospital, Wyoming; and Dr. G. Halsey Hunt, chief, Division of Hospitals, U. S. Public Health Service.

Doctor Carl Moyer's memorandum to the National Security Resources Board follows:

"Since the publication of the experimental work of Doctor Rosenthal, Doctor Coller, *et al*, orally administered salt solutions have been employed in the treatment of burns at the University of Michigan Hospital, Ann Arbor, Michigan; at the Wayne County General Hospital, Eloise, Michigan; and at Parkland Hospital, Dallas, Texas. Personal clinical experience, in the above-named hospitals, has convinced me that the orally administered salt solutions are valuable adjunctive agents in the treatment of shock incident to burns, fractures, peritonitis, and acute anaphylactoid reactions. Certain factors are important in governing the effectiveness of the oral administration of salt solutions. They are as follows:

"1. The composition of the salt solution: The most palatable salt solution is made by dissolving 3 to 4 grams of sodium chloride and 2 to 3 grams of sodium citrate in each liter of water. If sodium citrate is not available ordinary baking soda may be substituted for it.

"2. The concentration of salt should not be in excess of 140 milli-equivalents of sodium per liter. If the concentration is above this, vomiting and diarrhea become important complicating factors.

"3. Whenever profound peripheral circulatory collapse is present, the intravenous route of administration must be used until peripheral blood flow

has been reestablished. The salt solutions that we have found most satisfactory for this purpose are Hartmann's solution (Lactate-Ringer's solution) or plasma. In addition to the salt solution are plasma intravenously, whole blood is given concurrently whenever peripheral circulatory collapse exists. This materially implements the effectiveness of salt solution.

"The slightly hypotonic salt solution is the only drinking fluid permitted the injured individual until the edema of the injured parts begins to subside. Certain exceptions to this rule have to be made during the hot weather of summer when it is sometimes necessary to permit the partaking of some nonsalty water.

"As much as ten liters of the hypotonic salt solution have been drunk in the 24-hour period by adults who have been severely burned. Since salt solution has been substituted for water, as a drinkable fluid, no burned person who has lived for longer than three hours after being admitted to the hospital has suffered from anuria. The 'early toxemia phase' of burns has also failed to appear and the osmotic concentration of the plasma electrolytes has been well maintained.

"While further clinical research concerning the effectiveness of oral salt solution in the treatment of burns and other injuries is certainly in order, there is already sufficient evidence to suggest that this form of treatment should be used in any large-scale disaster involving the civilian population."

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The Journal extends to each of its readers heartiest wishes for a Very Merry Christmas and a Happy and Prosperous New Year

DOLLARS FOR DISABILITY*

THE *most valuable asset* of a doctor is his *earning power.*

Just as long as we are able to practice medicine —everything is lovely—*but* the moment we meet with a disability, either through sickness or accidents, the picture changes immediately—our overhead continues and expenses sky-rocket. The only means which we have of making ends meet is to dip into our savings or assets, and if our disability should last long enough, it is quite possible that we would find ourselves destitute.

A doctor, unfortunately, is just the opposite from the business man and salaried employee in regards to a disability. When the business man is confronted with a disability he is able to take off several months, if necessary, to recuperate. During this period his business continues to flourish. In other words, financially he has no worries. The salaried employee's income during a disability also continues. But we doctors immediately begin to wonder where the money will come from to tide us over during our disability.

The one and only way we have to protect our most valuable asset is through sickness and accident insurance—an insurance which will pay us a guaranteed income when most needed—during a period of disability.

Considering the fact that the most valuable asset of a doctor is definitely his earning power, it seems logical that we should protect it through good and sound sickness and accident insurance.

There is an old saying that is very true pertaining to disability insurance—"It is better to have it and not need it than to need it and not have it!"

There is another saying which is interesting that also applies to us doctors: "If you owned the goose that laid the golden eggs—would you insure it?" Why certainly you would! Well, we doctors, in a sense, are the same as the goose as long as we are able to maintain good health, but when disability strikes—the "golden eggs" are gone.

In the past we doctors of the Indiana State Medical Association have purchased disability policies from the various companies and agents. Knowing hardly anything about the various "loopholes" found in many of these policies, we have had to rely upon the statements made by the agents. And, in many, many instances when we filed a claim we found that the policy would not give us the protection we had expected when we needed it the most—during a period of disability.

Many of these policies contained unreasonable clauses, such as requiring you to be confined continuously within doors during a sickness, having to be injured a certain way. Many would continue to accept our premiums while we were good risks, *but* the moment we met with a disability our policies would be cancelled.

The Special Committee on Disability Insurance, which was appointed by the president upon the authorization of the Council, for the purpose of making a study of disability insurance to the end that standards might be established to which companies writing it might make their policies conform in order to obtain the approval of the Indiana State Medical Association, has had four meetings, and in preparation for those meetings has made a study of a number of policies recently and now being sold to physicians.

We have been most ably assisted by our legal counsel of the association, Mr. Albert Stump, and some of the most experienced and successful insurance consultants in the state of Indiana. To these men we owe a tremendous amount of gratitude.

The report and standards were submitted to the Reference Committee of the House of Delegates and were approved by both the committee and House of Delegates at our annual convention recently held at French Lick. This report was printed on pages 1119, 1120 and 1121 of the November issue of THE JOURNAL.

These standards are being submitted to all insurance companies writing noncancellable guaranteed renewable insurance in the state of Indiana. As soon as we hear their decision in regards to their interests in meeting these standards, you will be notified as to who the companies are and also the policy number.

If we doctors in the state of Indiana will purchase our disability policies in accordance with the standards set forth above, we will be in a position to depend on our policies when we need them the most—during a period of disability. Complete details will be announced soon along with the names of all companies meeting our standards.

Special Committee on Disability Insurance.

M. B. Catlett, Fort Wayne, Chairman
Elton R. Clarke, Kokomo
William H. Howard, Hammond
Kenneth L. Olson, South Bend

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* A report by M. B. Catlett, M.D., chairman of the Special Committee on Disability Insurance appointed to study the Sickness and Accident Insurance Problems of members of the Indiana State Medical Association.

POPULARITY OF TELEPHONE SEMINARS GROWS—AVAILABLE TO EVERY COUNTY SOCIETY

MORE than five hundred Indiana physicians from seventeen counties took advantage of the new telephone postgraduate service being offered jointly by the Indiana State Medical Association and the Indiana University School of Medicine during the first major test of the plan on Tuesday night, November 7. Stretching from the Ohio River to the northern edge of the state, and from the east to the west boundaries, physicians assembled in hospitals and hotels in their own communities to receive by leased wire the latest information on modern therapeutics.

Moderated by Dr. Reuben A. Solomon, the program heard by those listening was as follows: "Present-Day Status of Antibiotics," by William M. Dugan, M.D.; "ACTH and Cortisone," by Glenn W. Irwin, Jr., M.D.; "Autonomic Drugs," by Francis G. Henderson, M.D.; "N.R.H. Insulin," by Laura Hare, M.D.; "Veratrum Alkaloids," by Kenneth G. Kohlstaedt, M.D.

Eight additional counties took advantage of the program on December 5, and arrangements were made for more than 750 physicians to listen in. The December program was on "Chemotherapy of Urinary Tract Infections," with Dr. Henry O. Mertz as moderator. Dr. Evart M. Beck spoke on "Antibiotics"; Dr. Evanson B. Earp on "Mandelic Acid and Its Derivatives"; and Dr. Robert A. Garrett on "The Sulfa Group."

The Committee on Medical Education and Hospitals of the association has arranged, through the postgraduate committee of the medical school, to offer the profession a series of "Telephone Seminars" on the first Tuesday evening of each month. The program will begin at 8:00 P.M. and will continue for one hour. An announcement of the programs for the 1951 series will be made during the early part of December.

The flexibility and the possibilities of this type of program offer the profession an unlimited boundary of receiving the latest and most authoritative information possible in the rapid advancements being made by medical science. Under this program it will be possible through leased wires to supply the entire profession of the state with the latest knowledge of well-known authorities in various fields of medical science. Since hearing of the Indiana plan some of the surrounding states are attempting to create interest in this type of program, and suggestions have been made that it will be possible for various states to combine their efforts, thus permitting a larger listening audience, and the interchange of programs from the medical schools located in the various states.

The present program is conducted through an arrangement with the telephone companies whereby a private telephone line is leased to every county in the state desiring to participate. The members of the panel are then assembled before microphones located in the Indiana University Medical Center. At a signal from the school the entire network is cut in and doctors gathered before amplifiers in many cities are permitted to listen to the lectures or discussion taking place in Indianapolis. All participating physicians will receive a manual which will contain a picture and biographical sketch of each member of the panel, together with an organization outline of his paper, and reproductions of slides or charts that would normally be used, if present plans materialize.

Arrangements for these programs are being handled through the headquarters office, while the school is arranging the talent. The counties which participated in the November program state that they like this type of seminar; it is more convenient, saves travel time and expense, and much is gained by the profession through this type of communication.

The next program will be given at 8:00 P.M., Tuesday, January 2, 1951 and on the first Tuesday evening of each month thereafter. Counties desiring complete information as to cost and arrangements for participating should contact the headquarters office of the association, 1021 Hume Mansur Building, Indianapolis 4. It is necessary that arrangements be made well in advance in order that the technical details such as arranging and balancing the lines may be completed by the telephone company before the hour of the program.

Medical Panorama by the Associate Editor

Let Us Work No Mischief

Always the good physician must be alert to the old principle, or maxim, that whatever is done for the patient must be calculated to improve his condition and certainly not to make him worse. This, of course, is defined and modified by the extent of scientific knowledge at any given time, and we therefore welcome any new method which will make more certain that treatment of one condition does not lead to serious trouble in some other aspect.

Dr. T. H. Hunter, of St. Louis, presents a paper in *The Journal of the Missouri State Medical Association* for September, 1950, on Subacute Bacterial Endocarditis in which he discusses prophylaxis of the condition, as an important phase of the subject.

> Approximately 25 per cent of patients with bacterial endocarditis give a history of tooth extraction preceding the onset of the disease. A significant number of infections also follow instrumentation of the nasopharynx or genito-urinary tract—such procedures as tonsillectomy, sinus operations, cystoscopy, curettage of the uterus and even normal delivery. While it does not seem possible to prevent bacteremia completely at the time of these procedures, there is evidence that bacterial endocarditis can be prevented in susceptible patients by sufficiently intensive antibiotic prophylaxis. It is the doctor's responsibility to educate all patients with valvular or congenital heart disease as to the need for such prophylaxis, and they should be warned never to allow operations to be performed without telling the dentist or surgeon of the instructions they have had. What constitutes the best regimen for prophylaxis is not yet known with certainty, but no cases of bacterial endocarditis have been reported following tooth extractions in patients receiving penicillin in doses of 100,000 units every three hours intramuscularly starting at least six hours before operation and continued for at least forty-eight hours. In patients who cannot be hospitalized, procaine penicillin 500,000 units twice daily for the same period is recommended. It seems probable that aureomycin will be useful in prophylaxis not only because of its wide antibacterial spectrum, covering almost all of the organisms both gram positive and gram negative which may commonly enter the bloodstream, but also because it can be given by mouth. Sulfadiazine, however, has not proven adequate, and several cases of bacterial endocarditis have developed in the face of treatment with full doses of this drug.

This whole matter re-emphasizes the importance of having a good knowledge of the entire patient in addition to the part it is proposed to treat. Thus the general physical examination often proves to be critical rather than "routine." From there one could go on to comment on the recent proposal to require a certain amount of general practice before specialization. True, it is another chapter, but it is so important a matter that it bears mentioning in connection with any pertinent topic in the field of medicine or of medical education.

Socialized Medicine's Ills

The increase in reported sickness during Great Britain's first full year of socialized medicine has its significance for the United States. Much of the British program is embraced in the proposal of government medical care insurance which the Truman administration is promoting. This part of British experience with the system will hardly recommend it to Americans.

Sickness among adult Britons rose 8 percent and workdays lost through illness 22 percent, according to a government-sponsored survey. The increase occurred for the most part among women. The workdays lost by young women climbed 32 percent and by elderly women 41 percent, while the workdays lost by men went up 8 to 9 percent. Officials credit the growth of reported illness mainly to economic reasons—people now getting medical service who previously could not afford it.

But there are additional reasons. In the experience of European countries with compulsory sickness insurance it has long been observed that when workers are taxed for medical care they often claim it unnecessarily. That is the only way that many figure they can get something back for their money. The situation encourages a flood of patients with minor illnesses for which they would not ordinarily seek medical attention. Some doctors are consequently overworked to the point of hasty, careless diagnosis and treatment.

It is also a standard part of the government insurance system to give weekly cash payments to claimants. The chance to stay at home and live for a while with the aid of state funds frequently militates against a speedy return to work. In many instances the cash benefits delay recovery.

The more workdays lost through illness, the smaller the production and the lower the general standard of living.

These and other disadvantages of a national system of government insurance for medical care are getting no publicity from the Truman administration. British experience, however, is bringing out some of the missing facts.

—*Christian Science Monitor.*

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

A MINISTER SPEAKS OUT

We have had a little contact with ministers of the Gospel—men who held the degree of Doctor of Divinity. We have had conversations with some and we have heard some deliver sermons.

All of these men were dedicated to the same Christian life but many differed in their conception of ways to build the Kingdom of God. Most of them believed their function was to preach the Word. Others carried their ministry into the homes and lives of the less fortunate. A few carried their works into the field of economics and some of this latter group espoused the doctrines of Marx—at least to the extent of Socialism, just short of Communist Dictatorship.

We have just read a sermon delivered in Nashville, Tenn., by Dr. Walter R. Courtenay, pastor of the First Presbyterian Church of that city. His text was II Chronicles, Chapter 10, verses 1 to 16.

Dr. Courtenay takes pains to say he delivered this sermon as a Christian minister and that he is not a politician. He said that he was directing attention to a dangerous trend in America which concerns the whole future of the Christian Church and the safety of this country. He stated that in his sermon he was pleading for the deluded millions who were being tricked into the slavery of Socialism.

In reading the following quotes from Dr. Courtenay's sermon, let us remember that he was speaking in the heart of the Southland where the Democrat Party has little opposition. Here are direct quotations from Dr. Courtenay's sermon:

"Solomon was the original tax-and-spend leader. He came to the presidency of his country cultured, schooled and wealthy. Under his program of tax and spend the appearances of prosperity were present but the heart of prosperity was missing. The burdens of the people increased.

"In due time Solomon died, and his son, Rehoboam, came to power. He spurned the advice of the elders of Israel. He listened to the smart young men who knew all the answers. The successor to Solomon increased the taxes and continued the program of wasteful spending. The result was the death of the nation.

"Well, America's Solomon is dead and Rehoboam is in the White House. Our modern Rehoboam has turned his back on the elders of America and has listened to the young men who know all the answers. If the present policies are continued another five years I see no hope for the continuance of the American way of life.

"Socialism is a dishonest movement. It does not permit itself to be labeled. Most socialists talk about welfare, pensions, insurance, socialized medicine, aid to farmers—and all the time they are promoting socialism."

—Excerpt from an Editorial, Bloomington (Ind.) *Daily Herald-Telephone.*

GET A DOCTOR

Where is the gallant country doctor who got up at 1 A.M., rode through a sleet storm, swam his horse across the river and operated on a patient on the kitchen table?

He's swapped his saddle for a leather easy chair, his horse for membership in the city's best country club and the kitchen table for a clinic. He's given up his general practice and is specializing in cold weather diseases of the ear (left ear only, of course!).

I can't say that I can blame him. The pay is likely to be better, the hours much better, the country calls eliminated entirely and he is associated with others of his kind. He might even show you that in a city office he can do more good for more people than in the country; I wouldn't know about that.

But where does that leave us country folks? It leaves us sitting for hours and hours and hours in the outer office of a doctor we hope is in his private office. And it leaves us in serious trouble if we try to call a doctor for an emergency if the emergency does not occur at a time that fits the doctor's schedule. We don't even know that the doctor is still in practice. He may have joined the ever-hurrying migration of medical men to the metropolis.

This can't go on and get worse forever. It is already at a very critical point. The country doctors must invite instead of repel young newcomers and the country folks must make the job of country doctor more attractive.

Some small communities have actually set up clinics and offices and presented them to deserving young medics. Others have loaned beginners money to set up for themselves. I don't know what the solution is, but I know that a solution can be found and must be found.

We've got to do something besides bemoaning our fate as the disciples of Hippocrates desert the country field.—Scottsburg *Giveaway.*

(ok typ)

News Notes

Dr. Floyd T. Romberger, of Lafayette, was recently elected an honorary member of the American Society of Anesthesiologists. This membership was conferred because of Doctor Romberger's many activities in connection with the specialty of anesthesiology in the national association, and particularly because of his leadership in the specialty in the state. Very few physicians have received this honorary membership.

The **South Central Branch** of the **American Urological Society** will hold a seminar in Dallas, Texas, at the Adolphus Hotel, January 29 through February 2, 1951.

When the **American College of Surgeons** held its 36th convocation in Boston on October 28, the following initiates from Indiana were received into fellowship: **Dr. Harvey L. Bartsch**, South Bend; **Dr. John P. Birdzell**, Crown Point; **Dr. Leslie M. Bodnar**, South Bend; **Dr. R. Morton Bolman**, Fort Wayne; **Dr. William B. Ferguson**, Lafayette; **Dr. Joseph F. Ferrara, Jr.**, Franklin; **Dr. Warren R. Hickman**, Logansport; **Dr. Howard L. Kahn**, Indianapolis; **Dr. Reid L. Keenan**, Indianapolis; **Dr. Millard R. Marshall**, Whiting; **Dr. James A. McClintock**, Muncie; **Dr. Myron H. Nourse**, Indianapolis; **Dr. Cleon M. Schauwecker**, Greencastle; **Dr. Herbert A. Schiller**, South Bend; **Dr. Robert W. Wilkins**, Fort Wayne.

Dr. Harris B. Schumacker, Jr., of Indianapolis, has become a founding member of the new International Society of Angiology, and an associate editor of the society's journal, *Angiology*.

CONGRESSIONAL RECORD MISUSED

A charge of misuse of the Congressional Record for unethical purposes has been levelled at Representative John D. Dingell, of Michigan, by the American Medical Association.

In an open memorandum sent to every member of Congress, Dr. Elmer L. Henderson, president of the A.M.A., called attention to a widely distributed reprint of Dingell's speech attacking the Association's nationwide advertising campaign as a "Twenty Million Dollar Smear Campaign," and asked the Congressmen if Dingell's "willingness to damage a medium of great public usefulness and dependability," was, in their opinion, an ethical and proper use of the Congressional Record.

Dr. Cleon A. Nafe, of Indianapolis, was appointed to a three year term as a member of the board of governors of the American College of Surgeons, when that organization met recently in Boston.

Dr. L. E. Burney, of Indianapolis, was elected vice-president of the Association of State and Territorial Health Officers, when that organization met in Washington, D.C., late in October. At that time the association adopted a resolution against compulsory health insurance.

Dr. John Palm, of Brazil, was recently appointed a member of the Rehabilitation Medical Advisory Board of the American Legion. This Board is composed of physicians throughout the country who are called upon to give counsel to the rehabilitation and other divisions of the Legion, in order to provide more effective medical care for veterans.

VETERANS BENEFITS

World War II veterans may now receive wage credits for their military service under the new Social Security Amendments, according to Harold O. Mountjoy, Manager of the Indianapolis office of the Social Security Administration. He explained that the new law gives veterans credit for $160 in wages for each month of military service between September 16, 1940, and July 24, 1947. This will apply to all individuals who were in active military or naval service for at least 90 days and who had a discharge other than dishonorable.

All benefits under the Old Age and Survivors Insurance program are based on wage and self-employment service credits. Since the veteran received no credits while in service, he is now to receive them so that his benefits will not be lower than non-veterans. Since the Old Age and Survivors Insurance system pays both retirement benefits and death benefits to dependents of insured workers, this means an increase in the insurance protection of the veteran.

To receive these credits, it is only necessary that the veteran keep his discharge papers. When he retires or dies his discharge can be presented to the Social security office and his military wage credits will be added at that time.

HAND TALKING CHART

The difficulties which aphasic patients experience in communicating their wants to others were realized by Dr. Hamilton Cameron when he was recovering from a cerebral accident in 1943. During his convalescence Dr. Cameron devised a system of "hand talking" which he found helpful and which can be taught to the majority of aphasic individuals. Copies of the "Hand Talking Chart" and a discussion of its use may be obtained without cost by addressing Dr. Cameron at 601 W. 110th St., New York 25, N.Y.

A native of Auburn, **Dr. Howard T. Craven** has opened an office at 922 Hume Mansur Building, in Indianapolis, for the practice of general surgery. He is a 1944 graduate of the Indiana University School of Medicine, and spent his internship at the Staten Island Hospital in New York. Following this, Doctor Craven spent a year as surgical resident at Kings County Hospital in Brooklyn, New York, and then spent one year as resident in pathology and thirty months as surgical resident at the Methodist Hospital in Indianapolis.

Dr. W. L. Green, of Pekin, was guest of honor at a community dinner given by the residents of Pekin on October 29, in celebration of his completion of fifty years of practice in that community. More than 250 citizens, at whose birth Doctor Green had officiated, contributed to an anniversary gift for him.

Dr. C. Jules Heritier, of Columbia City, returned to active duty with the army, at the hospital at Camp Atterbury, Indiana, on October 20. Doctor Heritier had three years of active service in World War II.

Dr. R. Anthony Henn opened an office for the practice of general medicine and surgery in Greenfield on October 17. A 1946 graduate of Indiana University School of Medicine, he interned at Indianapolis General Hospital, before entering U. S. Naval Service. He was stationed at the Naval Hospital at Oakland, California, for two years, and then served as medical officer on a Navy troop transport. After thirty months of Naval service, he practiced surgery at the Luckey Hospital at Wolf Lake for a short time.

Announcement was made recently of the opening of an office for the practice of radiology in New Castle by **Dr. C. L. Poston**. A veteran of World War II, Doctor Poston is a graduate of Indiana University School of Medicine, and spent his internship at the Methodist Hospital in Indianapolis. He was in general practice in Richmond for several years before going to Cook County Hospital in Chicago for specialized training in radiology.

PUBLIC HEALTH SERVICE GRANTS

Among grants which were recently awarded by the Public Health Service, National Institute of Mental Health, were the following for Indiana:

Indiana University, Bloomington	$12,368	Clinical Psychology
Indiana University, Indianapolis	22,200	Graduate Psychiatry and Clinical Psychology.
Purdue University, Lafayette	3,600	Clinical Psychology.
Total	$38,168	

An office for the practice of pediatrics has been opened at 1517 N. Emerson Avenue, in Indianapolis, by **Dr. Paul J. Kirkhoff**, a 1946 graduate of Indiana University School of Medicine. He is a veteran of World War II, and recently completed his training at St. Vincent's Hospital in Indianapolis.

A native of Seymour, **Dr. C. A. Wiethoff** has returned there for the practice of surgery. He is a 1944 graduate of Indiana University School of Medicine and served his internship at the U. S. Naval Hospital at Key West, Florida. After his release from service, he spent one year's residency in pathology at the Indiana University Medical Center, and two years' residency at Indianapolis General Hospital. For the past fourteen months he has been associated with **Drs. F. B. Ramsey** and **J. E. Pilcher**, in Indianapolis.

Dr. James M. Brown, a 1949 graduate of the St. Louis University School of Medicine, has opened an office for general practice in Anderson. He recently completed his internship at St. Vincent's Hospital in Indianapolis, and is a veteran of World War II.

Dr. George D. Buckner, who recently completed a two-year residency at the Methodist Hospital, in Indianapolis, has opened an office for the practice of general surgery at 533 West Washington Boulevard, in Fort Wayne. Doctor Buckner is a 1944 graduate of Indiana University School of Medicine, and a veteran of World War II.

Dr. Patrick J. Lynam recently became associated with the Cameron Hospitals in Angola, in the practice of ophthalmology and otolaryngology. He is a graduate of Tufts Medical School in Boston, in 1929, interned in surgery at the City Hospital in Baltimore, and interned in pathology at Rhode Island Hospital in Providence. He entered private practice in Newport, Rhode Island, until he took postgraduate work at the Graduate Medical School at the University of Pennsylvania. Doctor Lynam entered service in the U. S. Naval Medical Corps. He was attached to the Tenth Army, with which he served in the Asiatic Theater of war. Following his release from service, he practiced in Hawaii.

Dr. J. R. S. Himebaugh, of Indianapolis, has returned to active service. He left September 25 for Fort Lewis, Washington, and expected an early overseas assignment. He served for 38 months in World War II, and has been in general practice in Indianapolis since that time.

Dr. Robert Seibel of Nashville has been recalled to naval duty. He left on October 18, to report to Brooks General Hospital at San Antonio, Texas.

Dr. Oscar Green, a resident in otolaryngology at Indiana University Medical Center, has reported for duty with the Army Medical Corps at Camp Atterbury.

Following a 26 months' internship and residency at the Methodist Hospital in Indianapolis, **Dr. Don G. Bock** enlisted in the Army and is stationed at Fort Sam Houston, Texas. He is a 1943 graduate of Indiana University School of Medicine.

Three graduates of Indiana University School of Medicine comprise the staff of a hospital on the Isle of Majuro in the Marshall Islands. They are **Dr. Richard E. Lahr**, a 1949 graduate, **Dr. Don Morgan**, a 1947 graduate, and **Dr. Frederick A. Clark**, also of the 1947 class.

Dr. John A. Glaubke, a 1949 graduate of Indiana University School of Medicine, is now stationed in Korea. After serving his internship at Tripler General Hospital in Honolulu, he decided to remain in Naval service.

Dr. Hubert C. Pirkle, a 1949 graduate of Indiana University School of Medicine is now in Korea, with the Marines.

Dr. Robert J. Harvey, of Indianapolis, is now battalion surgeon for the Third Battalion, Fifth Marines, stationed in Korea. He graduated from Indiana University School of Medicine in 1949, and interned at Indianapolis General Hospital.

A 1945 graduate of Indiana University School of Medicine, **Dr. John H. Kneidel** has begun the practice of radiology at St. Joseph's Hospital in Kokomo. Doctor Kneidel will also have charge of radiologic work in the hospital at Tipton.

Announcement has been made of the association of **Dr. Noel S. Graves** with **Dr. Harold R. Griffith** in the general practice of medicine in Vevay. Doctor Graves is a 1949 graduate of Indiana University School of Medicine.

Dr. John S. Szynal, a 1941 graduate of Tufts Medical School, has opened an office at 633 East 38th Street, in Indianapolis.

INDIANA UNIVERSITY NEWS NOTES

A new electron microscope, a rotary microtome and other equipment for the battle against cancer have been added to the laboratories of the Indiana University Medical Center, the gift of the Indiana Elks Association.

The new equipment for cancer research represents an investment of a part of the grants totaling nearly $95,000 to the Indiana University School of Medicine for this program during the past three years by the Elks Association.

When the Indiana State Board of Health moved to its new and greatly enlarged building just west of the Medical Center campus, the former headquarters, located on the campus proper, was taken over by the university. The four-story brick and limestone structure which served the Board of Health for eleven years is now being occupied by the Central Laboratories and the course in Medical Technology; offices of the Dean of the School of Medicine; Administrator of the Medical Center; the Medical Director; the Recorder of the Medical School; the News Bureau and Quarterly Bulletin office; headquarters for the Departments of Surgery, Medicine, Anesthesia and Pathology, with its general, surgical and students' laboratories. Headquarters for cancer research and teaching co-ordination also are in the building, along with the electron microscope.

A new cascade type oxygen system for the hospitals of the Medical Center, which eliminates both the handling of the heavy, awkward oxygen cylinders and any lapse of time in getting oxygen to the bedside of the patient, was recently put into use. Under the new system oxygen is stored in nine 40-foot cylinders, located on the campus and away from the buildings. From this reservoir the oxygen is piped into the hospitals with wall outlets at the bedside. The university hospitals are said to be the first in Indiana to adopt the cascade oxygen system.

Indiana University is now offering a new Bachelor of Science degree in Medical Record Library Science, providing three years of study on the Bloomington campus and one year's study at the I. U. Medical Center in Indianapolis, which has been approved by the Board of Trustees.

The course, to be directed by Miss Gertrude Gunn, head of the Department of Medical Records at the I. U. Medical Center, will qualify graduates for positions as medical record librarians in hospitals where detailed records are maintained on each patient.

Twelve students were graduated in September from Indiana University as qualified Medical Technologists with Bachelor of Science degrees after completing a year of practical experience and training in the Central Laboratories of the I. U. Medical Center which follows the three years of studies on the Bloomington campus.

There are twenty students in this year's class of Medical Technologists, seventeen young women and three men.

Seven students, members of Indiana University's first class in X-Ray Technology, have completed their year of training in the Department of Radiology at the Indiana University Medical Center and a new class of six students has been enrolled for similar training.

This course, inaugurated last year, qualifies students for all phases of x-ray laboratory work and with an additional year of service as a junior technician for examination by the American X-Ray Technicians' Registry. The course is presented under the direction of Dr. John A. Campbell, Medical Center roentgenologist.

A.M.A. WASHINGTON OFFICE NEWS

Election Takes Heavy Toll Among Leading Supporters of Truman Health Programs; Murray is in Line for Senate Committee Chairmanship, Replacing Elbert Thomas.

Last week's election eliminates from Capitol Hill at least half a dozen Senators and Representatives who led the fight for President Truman's national compulsory health program. Also defeated were a number of others who followed the administration line on most health legislation, but are not on record in favor of health insurance.

Conspicuous among health insurance advocates who lost out are *Senator Elbert Thomas* of Utah and *Representative Andrew Biemiller* of Wisconsin. Senator Thomas was a sponsor of S. 1679, the compulsory health insurance bill, and as chairman of the Senate Labor and Public Welfare Committee was in a position to push administration health bills. Representative Biemiller also introduced a health insurance bill in the House and fought vigorously but unsuccessfully for the administration's aid to medical education bill in the last session.

Others who openly indorsed Mr. Truman's plan, or might be expected to favor it, and who will not be back in January, include:

Representative *Helen Gahagan Douglas*, unsuccessful Senate candidate in California.

Senator *Claude Pepper* of Florida, co-sponsor of S. 1679, defeated in primary.

Senator *Glen Taylor* of Idaho, also a co-sponsor and also defeated in primary.

Senator *Francis Myers* of Pennsylvania, Democratic whip in Senate, defeated in the general election.

Senator *Frank P. Graham* of North Carolina, defeated in primaries.

At least as damaging to the administration was the general election defeat of *Senator Scott Lucas* of Illinois, the majority leader, and *Senator Millard Tydings* of Maryland, chairman of the powerful Armed Services Committee. However, neither Senator played a prominent role in health or medical legislation. Absence of all these loyal lieutenants will greatly lessen the administration's effectiveness in *all* fields of legislation. In other words, the setback cannot be measured in number of seats alone.

Dr. Scheele Urges Delay in Mass Blood Typing. Dr. Leonard A. Scheele, PHS Surgeon General, put a "*go slow*" sign on suggestions for a *nationwide blood typing program* in an address before the Association of State and Territorial Health Officers. He said such a program might be advisable later, but for the present, "The best thinking of governmental agencies and professional societies . . . is that any state or local programs for mass blood-typing should be in conformity with a National Civil Defense program, the American Red Cross, American Medical Association, American Association of Blood Banks and American Hospital Association. Emphasis should be placed on typing people who can and will give blood, either in advance for storage in blood banks or for use at the time of an emergency." He said that the *immediate need* is to identify in advance type 0 donors in the 18 to 60 age group. Dr. Scheele cautioned that mass blood-typing campaigns would place severe demands on manpower and supplies of typing serum, and that errors might be expected from hastily trained personnel. He said the interest in mass blood-typing grew out of a fear that large numbers of injured persons would be in immediate need of whole blood transfusions in event of an atomic bombing. "Actually," Dr. Scheele said, "plasma and plasma substitutes, such as oral salt solution—which require no typing—*will be the emergency treatment of choice in the event of disaster.*" In the same address Dr. Scheele requested the public health officers to survey their staffs with a view to releasing some skilled personnel for service abroad on Point Four and other similar programs. He said about 300 medical people are needed for these programs.

More Orderly Policy for Calling Up Medical Reserves. The slower military tempo is reflected in orders from Defense Secretary Marshall for more orderly call-up of reserves. (Services are not bound by these regulations, but are allowed to waive them for over-riding military considerations.) New schedule is designed to *let each individual know just about what his chances are of being recalled, and when.* Each service is to determine its requirements and make requisitions six months in advance of recall. Lists of all reserves are to be screened, and men judged to be in line for recall are to be notified. Reserves *not* placed on the ready-to-go list will *not* be notified personally, but fact they receive no word is evidence *they will not be called for at least four months.* Men placed on the list, and so notified, are assured 30 days between orders to report for duty and date for reporting.

Dr. Rusk, Army and Defense Department Re-Define Doctor-Draft Rules. Regulations issued by *Defense Department* and *Army*, and a policy statement by *Dr. Howard A. Rusk* offer some help in clearing up confusion on the doctor-draft. Dr. Rusk, chairman of the National Advisory Board on the draft, says that registrants making application for reserve commissions *up to the time they actually are inducted* will be eligible for the $100 pay bonus, when and if the commission finally is granted. However, if they delay application until after induction, the $100 monthly bonus is denied. Under Dr. Rusk's interpretation, a registrant may apply for a commission even during the 21 day period between notice to report for induction and induction. A *Navy* spokesman concurred in this policy. However, the *Army* Surgeon General's Office states that men will not be granted Army commissions during this period.

In a policy directive to all three services, Defense Department announced that priority one physicians applying for reserve commissions *prior to receipt of notice to take their physicals* will have their choice of service, providing they are acceptable to that service and it has use for them. Whatever the implications of this offer, by far the highest percentage is likely to go to the Army. A schedule of distribution, accompanying the Defense Department regulation, shows that Army will receive *98 percent* of the first 1,000 reserves from priority one. When the total reaches 6,000 Army still will be taking *70 percent.*

Navy Changes Policy on Accepting Volunteers in Draft-Eligible Categories. While Army has stated it will offer reserve commissions to all men in draft-eligible categories at the time of their physical examination or any time prior to induction, Navy has clamped down on its reserve commission policy. *No former ASTP with less than 21 months active duty* (former Army men in draft-eligible categories) *will be accepted by Navy.* Former V-12s (Navy) and those deferred to continue their education during World War II may still volunteer for Navy reserves. Navy says it will continue to call to duty V-12s in its unorganized reserves as well as reserves in organized units that are called to duty with their units. However, next January, when Navy gets back its 570 V-12 reserves loaned to Army, these doctors will remain on duty with Navy to replace older reserves with World War II service. The more experienced reserves will be released on the basis of the amount of time spent in service during the last war.

Incidentally, the 922 men Army has requested from Selective Service will merely *replace the 570 Navy men on Army duty and 300 of its reserves* Army called up on mandatory orders. The reserves will be allowed to return to civilian life and the Navy men will go on active duty with their own branch of service.

Air Force, which has very limited reserve strength, reports it has commissioned *500 volunteers* since August 1, and is now processing another 300 doctors. Most of these physicians come from draft-eligible sources. Neither Air Force nor Navy has called on Selective Service to supply men.

N.S.R.B. Says It Has Neither Funds Nor Authority for Medical Stockpiling. Although purchase and maintenance of regional medical stockpiles has been designated a federal responsibility, spokesman for *National Security Resources Board* explain that their agency has neither money nor authority to start the job. This reaction came after the New York State Health Commissioner accused NSRB, the top civil defense agency, of retarding the rest of the country. Dr. Herman E. Hilleboe said, "The Federal Government's slowness in handling the medical supply program is the only snag in the state's rapidly developing medical preparedness."

For the time being, according to NSRB officials, *there is no legal way for this agency to start buying and storing.* The civil defense program, as advanced by NSRB, places most responsibility on local and state organizations, but makes the federal government responsible for medical stockpiles, which would be located at central points, accessible to areas which might be overwhelmed with medical demands in case of atomic attack.

Last September, the President asked Congress to create a new *Civil Defense Administration* with broad *operating* powers, in contrast to *NSRB's planning and advisory* powers. The President said he planned to set up the agency by executive order if Congress did not act, and to finance it with emergency funds. When and if this is done, the new agency could start collecting medical supplies. Meanwhile, officials said NSRB is doing all it can in the way of planning and surveying, so there will be a minimum of delay when action is authorized.

Deaths

James B. Griffith, M.D., of Crawfordsville, died suddenly on November 6, at the age of seventy-seven. He was an honorary member of the Montgomery County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association. Doctor Griffith was a graduate of the Medical College of Indiana, in Indianapolis, in 1899, and began the practice of medicine in Alamo in 1900. He established an office in Crawfordsville in 1923, and had practiced there continuously since then.

William H. Harrison, M.D., of Kokomo, died on October 23, after a brief illness. He was eighty-six years old. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1896, and began the practice of medicine in Kokomo in 1897, where he had practiced for fifty-three years. He was an honorary member of the Howard County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Glen D. Kimball, M.D., of Marion, died on September 28, at the age of eighty. He was a graduate of the Rush Medical College, of Chicago, in 1892, and began the practice of medicine in Marion. Later, he became attached to the Army medical service, in which capacity he continued until his retirement in 1940. During World War II he resumed practice in Marion.

Evan Albert Evans, M.D., of Rosedale, died on October 16, at the age of seventy-one. He graduated from the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1906. He began the practice of medicine in Rosedale, but moved to Clinton in 1912, where he practiced for thirty-three years, before returning to Rosedale.

Hugh M. Mullikin, M.D., of Terre Haute, died on October 2, at the age of seventy-four. He graduated from the Miami Medical College, in Cincinnati, in 1903, and had practiced in Terre Haute until his retirement, two years ago. He was a member of the Vigo County Medical Society, the Indiana State Medical Association, and the American Medical Association.

George G. Wimmer, M.D., of Mt. Etna, died on October 13 after a long illness. He was seventy-five years of age. A graduate of the Beaumont Hospital Medical College of St. Louis, in 1899, he began his practice in Mt. Etna, where he had remained. He was a veteran of World War I, and was a member of the Huntington County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Albert Seaton, M.D., of Indianapolis, died on November 12 after a brief illness. He was seventy years old. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1904, and had practiced in Indianapolis since that time. Doctor Seaton was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Loren E. Lewis, M.D., of Valparaiso, died suddenly on November 11, at the age of sixty-eight. He graduated from the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1907, and had practiced in Valparaiso for forty-three years.

Walter R. Shobe, M.D., of Indianapolis, died on November 8. He was thirty-two years old. A graduate of the Meharry Medical College of Nashville, Tennessee, in 1944, Doctor Shobe had practiced in Indianapolis for six years. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

November 12, 1950.

Roll call showed the following present: W. L. Portteus, M.D., chairman; C. J. Clark, M.D.; Alfred Ellison, M.D.; J. William Wright, M.D.; Roy V. Myers, M.D.

Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith, executive secretary. and James A. Waggener, field secretary.

Guests: L. E. Burney, M.D., State Health Commissioner; Mrs. Gordon Johnson, president, Indiana State Nurses Association; Elton R. Clarke, M.D., councilor, and chairman of Committee on Retirement Income Pension Plan.

Membership Report

Number of members November 7, 1950	3,654*
Number of members November 7, 1949	3,723
Loss over last year	69
Number of members December 31, 1949	3,758

* Includes 22 in military service (gratis); 152 $10 members (residents and interns) and 211 senior members.

Statements of receipts and expenditures for September and October for the association and THE JOURNAL were approved.

Treasurer's Office

On motion of Drs. Ellison and Clark, the treasurer was directed to invest $2,000 from the Medical Defense Fund in United States Government bonds.

Annual audit of books. On motion of Drs. Ellison and Wright, the George S. Olive and Company was approved for auditing the association's books.

The executive secretary was directed to purchase a wrist watch with suitable engraving for presentation to the retiring treasurer, the cost not to exceed $125, on motion of Drs. Ellison and Wright.

1951 Annual Session, Indianapolis, October 29, 30 and 31, 1950

The committee accepted the quotation of $1,750 from the Murat Temple for rental of the Temple for the 1951 meeting.

Technical Exhibit

a. Request of the Medco Products Company of Tulsa, Oklahoma, for exhibit space was approved, providing the company's product is A.M.A. Council-accepted.

b. A letter from Burroughs Wellcome & Co. regarding longer intermissions to enable physicians to visit the technical exhibits was referred to the Committee on Scientific Work.

Banquet speaker. The president proposed Reverend Norman Vincent Peale of New York as the banquet speaker, and the executive secretary is to contact the Harold R. Peat Agency concerning Rev. Peale's availability and fee.

Legislative Matters

Local:

Dr. L. E. Burney, state health commissioner, explained the recent referendum for a full-time health department in Fayette county. The committee reaffirmed its approval of the 1947 law which provides machinery for establishment of county or combined county full-time health departments.

A resolution adopted by the Daviess-Martin County Medical Society opposing the bill providing use of state funds to help finance county full-time local health departments as sponsored by the Indiana Advisory Health Council and the Indiana Community Health Organization Committee was read. Since the association had approved the bill in 1948, the committee did not see fit to change its position. The executive secretary was instructed to suggest to the Daviess-Martin County Medical Society that it invite either the president or the secretary of the Indiana State Board of Health to discuss the bill before the members of the society.

On motion of Drs. Clark and Ellison, the executive secretary was directed to participate in the pre-legislative conference of the Indiana State Chamber of Commerce, November 26, 27 and 28, 1950.

Organization Matters

Nurse improvement program of I. S. N. A. The program of the Indiana State Nurses Association, Indiana State League of Nursing Education, and the Indiana State Board of Nurses' Registration and Nursing Education was explained by Mrs. Gordon Johnson, president of the Indiana State Nurses Association. On motion of Drs. Ellison and Clark, the Executive Committee approved assisting with the financing of the program and approved the invitation to the executive secretary to serve on the Special Finance Committee. The amount of financial assistance to be given is to be decided later.

Disability insurance. The executive secretary explained the plan of the special Council Committee on Disability Insurance for submitting specifications for policies to the companies writing non-cancellable health and accident insurance in Indiana.

On motion of Drs. Ellison and Clark, the committee took under advisement the recommendation of the Committees on Rural Health, School Health

and Physical Education and Maternal and Child Health that a health coordinator be employed.

On motion of Drs. Ellison and Clark, Dr. E. S. Jones of Hammond was appointed as representative of the association at a conference on Temporary Cash Sickness Benefits Legislation, to be held in New York, Friday, November 17, under sponsorship of the Council on Medical Service of the American Medical Association.

Survey cards. On motion of Drs. Wright and Clark, the cards returned on the survey of medical laboratory workers are to be turned over to the Indiana Academy of General Practice for any use it cares to make of them, and then they are to be turned over to the Indiana Association of Pathologists for its use.

The committee appropriated $300 to the Committee on Military Manpower, on motion of Drs. Ellison and Clark.

Badges are to be supplied to the Woman's Auxiliary for their 1951 annual meeting in Terre Haute, on motion of Drs. Ellison and Clark.

$100 was voted to the Indiana Council for Children and Youth, on motion of Drs. Wright and Clark.

Membership in the Indiana State Chamber of Commerce for 1950-51 was continued at $100, on motion of Drs. Clark and Ellison.

Retirement income pension plan. After Dr. Elton R. Clarke, chairman of the Committee on Retirement Income Pension Plan, reviewed the steps taken in presenting the Independent Plan of the Jefferson National Life Insurance Company to the House of Delegates for approval, the president of the association was instructed to write the president of the Underwriters Association to the effect that any insurance company presenting a policy as good or better will be recommended to the delegates for approval by Dr. Clarke's committee.

It was agreed that in the event the American Medical Association takes over the standardization of hospitals a general practitioner should be a member of the Council which does the evaluation, in keeping with the resolution adopted by the American Academy of General Practice. The committee took this action in response to a request from E. S. Jones, M.D., of Hammond, alternate delegate to the American Medical Association.

On motion of Drs. Clark and Wright, $100 was voted to the National Society for Medical Research.

On motion of Drs. Clark and Ellison, the committee delegated Dr. Louis E. How, chairman of the Committee on Rural Health, and the field secretary to attend the Sixth National Conference on Rural Health at Memphis, Tennessee, February 23 and 24, 1951.

The Journal

Total advertising in October issue	$2,335.90
Total advertising in November issue	2,402.38

There being no further business, the Executive Committee adjourned to meet again on Saturday night, January 13, 1951, or in December, 1950, upon call of the chairman.

COMMITTEE ON PUBLICITY

October 6, 1950

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; D. S. Megenhardt, M.D.; Ray E. Smith, executive secretary and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of November 5, 1950—"Tonsils"

Week of November 12, 1950—"So You Have A Favorite Disease"

A letter from Dr. John W. McCallister of Fort Wayne was read and it was decided the reply of the executive secretary disposed of the matter.

A letter from Mary M. Lemons of Richmond was read, in which she requested a speaker for a meeting on November 2, 1950. It was decided to ask Dr. Joseph Clevenger, of Muncie to accept the engagement.

The committee discussed further the matter of publishing various pamphlets for public distribution through the offices of physicians. The field secretary reported that the cost of publishing 200,000 four-page pamphlets would approximate $600 if printed in one color, and $810 if printed in two colors. The matter is to be discussed further, with no action being taken at this time.

COMMITTEE ON PUBLICITY

October 20, 1950

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; D. S. Megenhardt, M.D.; Frank B. Ramsey, M.D.; and Ray E. Smith, executive secretary.

The following "Hints on Health" columns were approved:

Week of November 19, 1950—"Right or Left Handed?"

Week of November 26, 1950—"Lunch Box Nutrition"

Week of December 3, 1950—"Postnasal Discharge"

The matter of the committee publishing a series of pamphlets for public distribution through the offices of the membership was discussed further, with no decision being made at this time.

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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

COUNCILOR DISTRICT MEETINGS

SEVENTH COUNCILOR DISTRICT

The Seventh District Medical Society held its fall meeting in Pittsboro, on October 18. Sixty-five members and their wives attended the session. Dr. William Province, of Franklin, was elected president-elect, and he will succeed Dr. E. M. Pitkin, of Martinsville, who assumed the presidency at Pittsboro. Dr. Ralph V. Everly, of Indianapolis, was re-elected secretary-treasurer. Dr. Roy A. Geider, of Indianapolis, was re-elected councilor of the district. Members of the Woman's Auxiliary were entertained at a doll style show in the afternoon, and in the evening both the members and their wives assembled to hear Mr. Carroll Reynolds, of the Americanism Department of the Indianapolis Chamber of Commerce speak on the growth of socialism in the United States. A film entitled "Joe Turner, American," was shown, and music was supplied by the Continental Trio, of Indianapolis. The next meeting of the society will be held in Indianapolis in May 1951.

THIRTEENTH COUNCILOR DISTRICT

Dr. Kenneth L. Olson of South Bend was re-elected councilor from the Thirteenth District at the annual meeting of the district medical society in Michigan City on November 8. Other officers elected were Dr. Milo G. Meyer of Michigan City, president; Dr. Floyd S. Martin of Goshen, vice-president, and Dr. O. E. Wilson, secretary-treasurer (re-elected).

South Bend was selected as the site for the 1951 meeting some Wednesday next November.

The scientific program included a clinicopathological conference by the South Bend Medical Foundation; "ACTH and Cortisone in Treatment of Arthritis," by Dr. Edward F. Rosenberg, of Chicago; "Allergy Therapy—Recent Progress and Role of General Practitioner," by Dr. Samuel W. Feinberg of Chicago, and "Banthine and the Ulcer Problem," by Dr. Keith S. Grimson of Durham, North Carolina.

Dr. Alfred Ellison of South Bend, president of the state association, spoke at the luncheon meeting. The principal address at the banquet was delivered by Dr. Carl F. Steinhoff of Chicago, a retired brigadier general, who discussed the doctor's role in civilian atomic defense. Others who spoke were Shepard J. Crumpacker of South Bend, newly-elected Congressman from the Third district; Dr. J. William Wright of Indianapolis, president-elect, and Ray E. Smith, executive secretary.

Dr. Louis E. How of Lakeville, district president, presided at the meeting. Dr. Thomas Armstrong of Michigan City was chairman of the arrangements committee.

The Woman's Auxiliary met at the Pottawattomi Country Club in the afternoon. Mrs. D. E. Lybrook of Galveston, state president, attended. Auxiliary officers elected were: Mrs. John Richter, LaPorte, chairman for the Thirteenth District, and Mrs. K. L. Olson, South Bend, secretary.

LOCAL SOCIETY REPORTS

Boone County Medical Society members met at Witham Memorial Hospital in Lebanon on September 5. Sixteen members were present to hear Dr. D. S. Megenhardt, of Indianapolis, speak on "Postoperative Care."

Another meeting was held on October 3, when seventeen members were present. A state board of health film on "Cancer of the Breast" was shown.

Carroll County Medical Society members held a meeting in Delphi on October 18. Sixteen members were present. Mr. Tom Sternberg, an Upjohn representative, discussed "Anticoagulants," and two films were shown: one on "Cancer, the Problem of Early Diagnosis," and another on "Breast Cancer, the Problem of Early Diagnosis."

Clay County Medical Society members met at the Elks Home in Brazil on October 10. Ten members were present to hear a discussion on insurance programs.

Clinton County Medical Society members met at the Clinton County Hospital, in Frankfort, on September 5. Twelve members were present to hear Dr. I. E. Michael, of Frankfort, speak on "Obesity and Endocrine Relation."

Another meeting was held at the Clinton County Hospital in Frankfort on October 3. Dr. Francis E. Carrel, of Frankfort, spoke on "Gerontology." Ten members were present.

Floyd County Medical Society members held a business meeting at the Legion Home in New Albany on September 8, when seventeen members were present.

A special meeting was held on September 19 at the St. Edwards Hospital in New Albany, to consider the resolution of the board of directors of Mutual Medical Insurance, Inc. Seventeen members were present.

Another meeting was held on October 13, at the American Legion Home in New Albany. Dr. O. O. Miller, of Louisville, presented a paper on "Boeck's Sarcoidosis." Eighteen members and three guests were present.

Fountain-Warren County Medical Society members met at the Methodist Church in Veedersburg on October 5. This was a business meeting, and the eight members present held a discussion of governmental affairs as they affect medicine.

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Grant County Medical Society members held a meeting at the Marion Veterans Hospital in Marion on September 21. Forty members were in attendance. The guest speaker was Dr. Adolph Loveman, of Louisville, Kentucky, who spoke on "Skin Lesions."

Greene County Medical Society members held a meeting at the Freeman Greene County Hospital in Linton on October 12. Plans were made for mass immunization of the school children in the county. Eight members were present.

Gibson County Medical Society members met at the Hotel Emerson in Princeton on September 11. Guest speaker was Dr. H. B. Shumacker, of Indianapolis, whose subject was "The Acute Abdomen." Thirty-four members and guests were present.

Hendricks County Medical Society members held a meeting at Avon on September 12. This was a business meeting, and seventeen members were present.

Huntington County Medical Society members met at Hotel LaFountain at Huntington, on October 3. The twenty-four members and guests who were present heard Dr. Thomas James, Jr., of Huntington, speak on "Medical Aspects of Atomic Warfare."

Jasper-Newton County Medical Society members held their first fall meeting at the Jasper County Hospital in Rensselaer on October 18. The guest speaker was Dr. Alfred Ellison, of South Bend, who gave a report on the state meeting at French Lick. Seventeen members were present.

Madison County Medical Society members met at the Anderson Country Club on October 16. Fifty-four members and guests were present. A colored sound film on "Medical Effects of the Atomic Bomb" was shown.

Orange County Medical Society members held a meeting at West Baden on September 5. The eight members present appointed a Procurement Committee: Dr. Keith Hammond, of Paoli; Dr. H. L. Miller, of West Baden; and Dr. Philip Hodgin, of Orleans.

Another meeting was held on November 7, when a Doctors Exchange was established. A film was shown on "Use of Sodium Pentothal In Obstetrics." Eight members were present.

Randolph County Medical Society members held a business meeting at the Union City Country Club on September 13. Seventeen members were in attendance.

Another meeting was held at the Randolph County Hospital in Winchester on October 9. Dr. G. R. DeRyke of Bluffton spoke on "Blood and Serum Tests in Malignancy." Twelve members were present.

Vanderburgh County Medical Society members met at the Hotel McCurdy in Evansville on November 14. Dr. Cyril MacBryde, of St. Louis, was the guest speaker. His subject was "New Developments in the Treatment of Diabetes."

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. D. E. Lybrook, Galveston.

President-elect—Mrs. F. M. Fargher, Michigan City.

Corresponding Secretary—Mrs. E. W. Bailey, Logansport.

Recording Secretary—Mrs. H. P. Sloan, New Albany.

Treasurer—Mrs. Robert Bolin, Elkhart.

Publicity—Mrs. F. M. Gastineau, Indianapolis.

The Woman's Auxiliary, under the direction of the Indiana State Medical Association, has carried on organization, national education campaign, and political action. Because we had ready and helpful cooperation from the medical association, five county auxiliaries have been added to our membership, many resolutions and endorsements have been secured, and surely some of the results in the political campaign were due to our efforts at the polls.

Auxiliary members transported voters, were baby sitters, and one member took over the preparation of a meal, thus relieving the house mother to vote during that hour! While we realize legislation for socialized medicine is only delayed, we are determined to continue promoting a voluntary health program.

The seventh National Conference of Presidents, Presidents-elect, and National Chairmen was held in Chicago November 2 and 3. Mrs. Frank Gastineau, national director from Indiana, Mrs. F. M. Fargher, president-elect, and Mrs. D. E. Lybrook, president, attended. Indiana led all the forty-four states represented at the conference in the number of resolutions secured, and equalled any of the states reporting on activities in legislation and public relations. The panel discussion on organization included the Indiana president's report. One of the projects assigned was to have an active auxiliary or a member-at-large in each of the ninety-two counties in Indiana. Indiana fulfilled this requirement.

This year we are emphasizing "Nurse Recruitment," and are planning toward two new committees, one on Rural Health, and one on County Health Conferences.

Our Christmas greetings to the Indiana State Medical Association and to all doctors' wives are our best wishes, gratefully and sincerely extended.

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